

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VRA 15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last WILLIAM SIDNEY ADAMS, Sr.			2a. DATE OF DEATH Month Day Year January 11, 1980			2b. HOUR 5:45 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 7, 1916		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Salisbury, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shirt Cutter			12b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg. Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 121 Benjamin Ave.		
14. FATHER'S NAME First Middle Last Wilbur Frisk Adams			15. MOTHER'S MAIDEN NAME First Middle Last Nellie Virginia Jenkins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. WW 11 214-10-8426		17. INFORMANT Address Mrs. Juanita Adams (wife) same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe recurrent abscess and rectal infection 3 months</u> 2880 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Leucopenia, anaemia & thrombocytopenia 1 yr</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemopoietic dysplasia Probable Preleukemia 1 yr</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) COPD.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/23/79</u> , 19 <u>79</u> , to <u>1/10/80</u> , 19 <u>80</u> , that (I) (we) lost the deceased alive on <u>1/10/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>BAL K. AGARWAL</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/11/80		
22d. PHYSICIAN'S NAME (Type) BAL K. AGARWAL			22e. ADDRESS 237 FLORIDA AVE SALISBURY MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/14/80		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park			23d. LOCATION (City or Town) (County) (State) Salisbury Wic. Maryland				
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. REC'D BY REGISTRAR JAN 16 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

and only

and in the general house

10/10/71

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

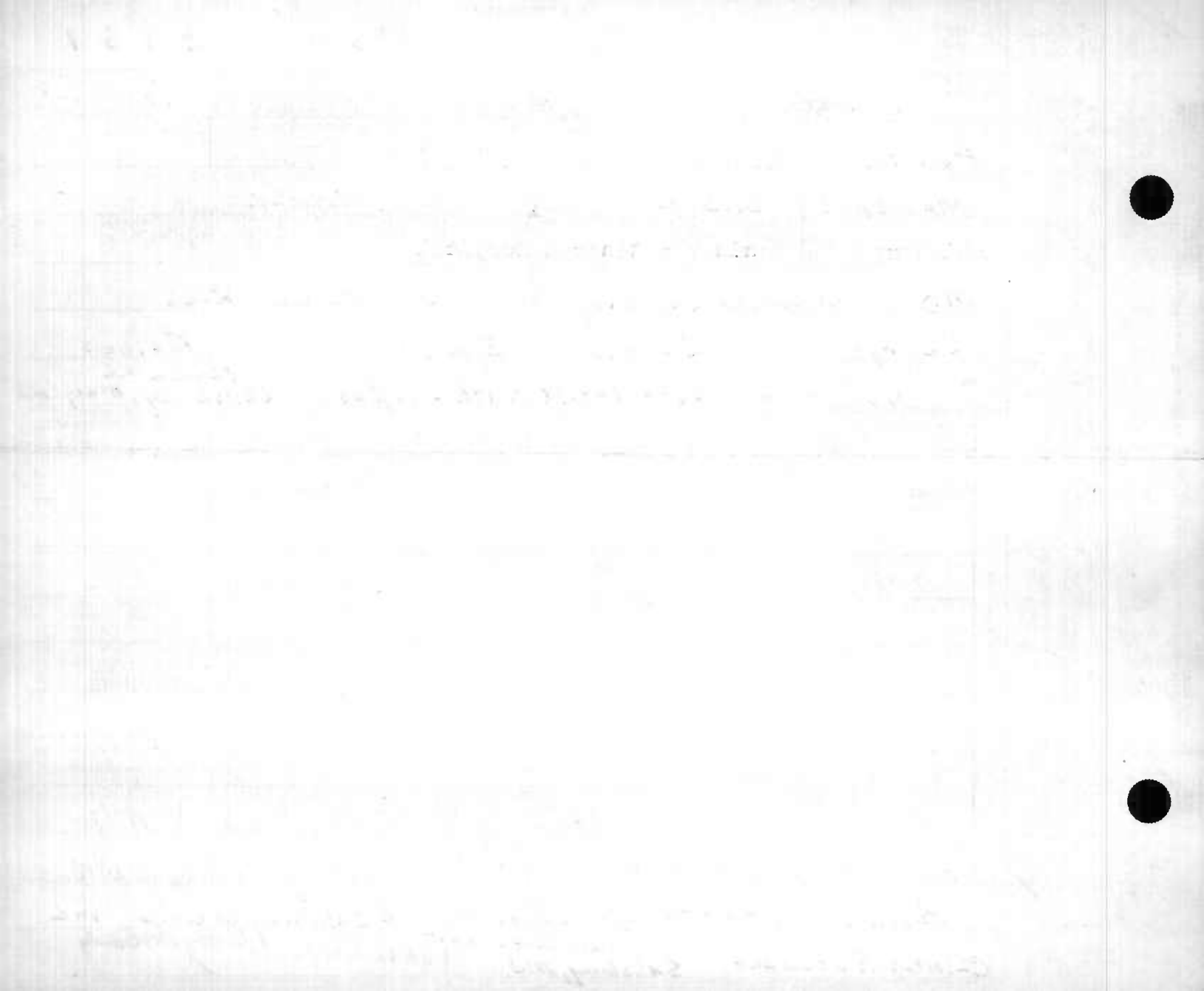
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 02656			
FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALLIE BLANCHE ADKINS										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 1-9-80, MONTH DAY YEAR		2b. HOUR A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 15 03		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 1-9-80 MONTH DAY YEAR		2d. HOUR 40A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Parsonsbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 271				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.				13b. COUNTY Wicomico				13c. CITY OR TOWN Parsonsbury				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 271	
14. FATHER'S NAME FIRST MIDDLE LAST George Lloyd						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Jackson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 213-60-9482		17. INFORMANT (daughter) ADDRESS Hilda Townsend, Parsonsbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												(b) Hypertensive Cardiovascular Disease years			
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 1-10-80							
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-11-80		23c. NAME OF CEMETERY OR CREMATORY Walston Switch Cemetery, Walston Switch, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE Wicomico					
24. FUNERAL DIRECTOR NAME ADDRESS Wilson Funeral Home, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR JAN 16 1980				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 002657	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Odessa AMES				2a. DATE OF DEATH MONTH DAY YEAR January 3, 1980				2b. HOUR 8:05 P	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 12 27 07		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Plover Road	
14. FATHER'S NAME FIRST MIDDLE LAST George Haines				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Haines				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 220-01-8238				17. INFORMANT Ruth Douglas				ADDRESS Plover Rd Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Cardiovascular (c) Due to, or as a consequence of Vessel										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus Advanced Peripheral Vascular Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/30/80 to 1/4/80, that (I) (we) last saw the deceased alive on 1/4/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Helen M. Baldado, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/7/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen M. Baldado, M.D.				22e. ADDRESS 237 Florida Avenue, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-8-79		23c. NAME OF CEMETERY OR CREMATORY Green Glen Memorial		23d. LOCATION CITY OR TOWN Salisbury Wicomico		COUNTY		STATE MD	
24. FUNERAL DIRECTOR NAME Clinton F. Stewart				ADDRESS West Rd. & Oliver St. Salisbury, Md.				DATE REC'D. BY REGISTRAR JAN 24 1980		REGISTRAR'S SIGNATURE [Signature]	

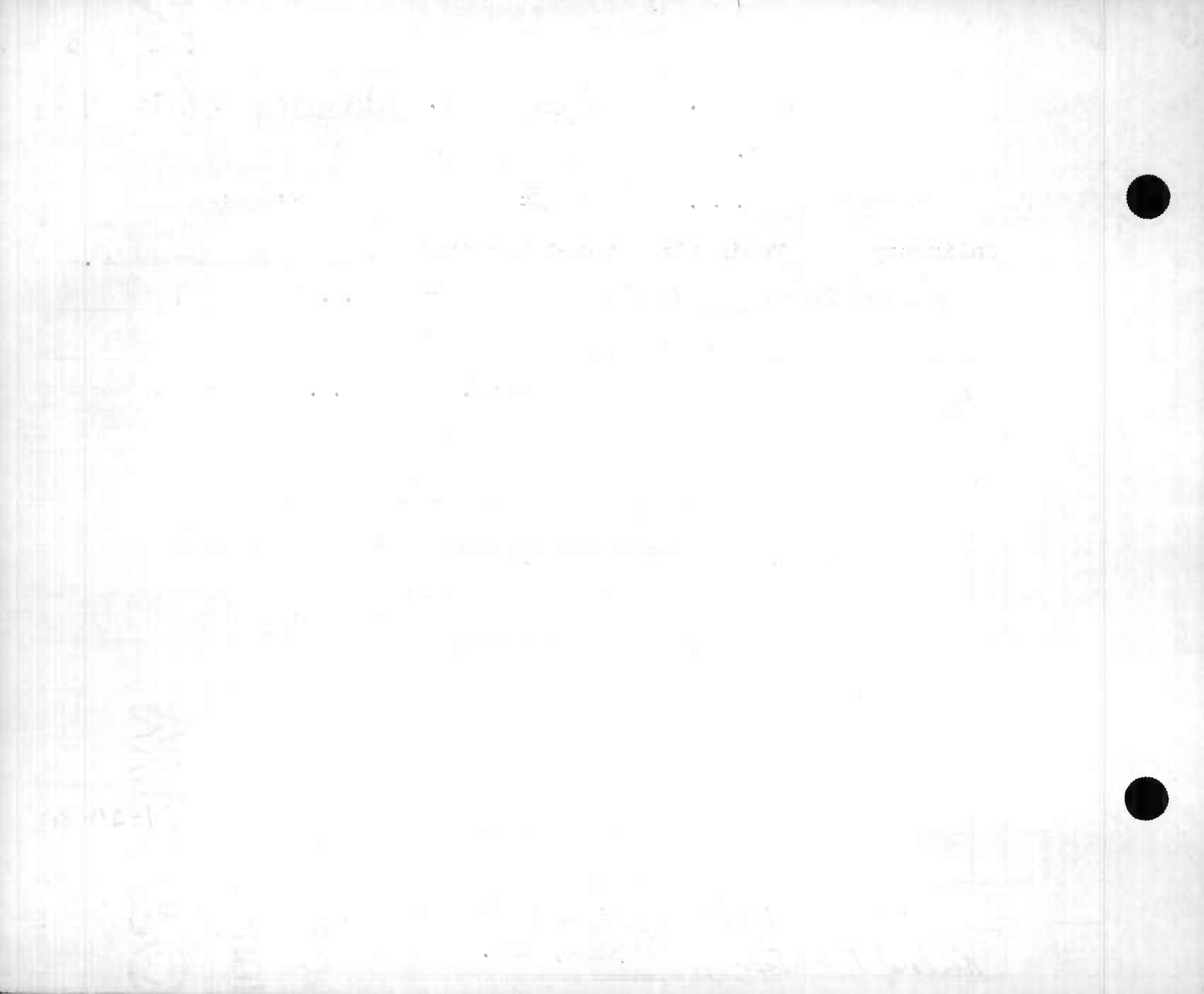


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 0 0 2 6 5 8 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Victor		MIDDLE B.		LAST Baker Sr.		2a. DATE OF DEATH MONTH DAY YEAR January 27, 1980	
3. SEX male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65		7b. HOUR 9 ⁰⁰ P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner - Oil Company Dist.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Delaware		13b. COUNTY Sussex		13c. CITY OR TOWN Millsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 3 Box 225B	
14. FATHER'S NAME FIRST MIDDLE LAST David Baker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Baker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 221-22-3049		17. INFORMANT ADDRESS Mary A. Baker R.D. 3, Millsboro, Delaware			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - pulmonary arrest 410 - DUE TO, OR AS A CONSEQUENCE OF (b) acute MI - CHF DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 min 1 hr 5-10 yr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/20/80 to 1/27/80, that (I) (we) last saw the deceased alive on 1/27/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-27-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. L. Raffetto				22e. ADDRESS P.O. Box					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/1980		23c. NAME OF CEMETERY OR CREMATORY Millsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Millsboro, Sussex Co., Delaware			
24. FUNERAL DIRECTOR NAME Richard T. Watson				ADDRESS Millsboro, Dela.		25a. DATE REC'D. BY REGISTRAR FEB 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

BP



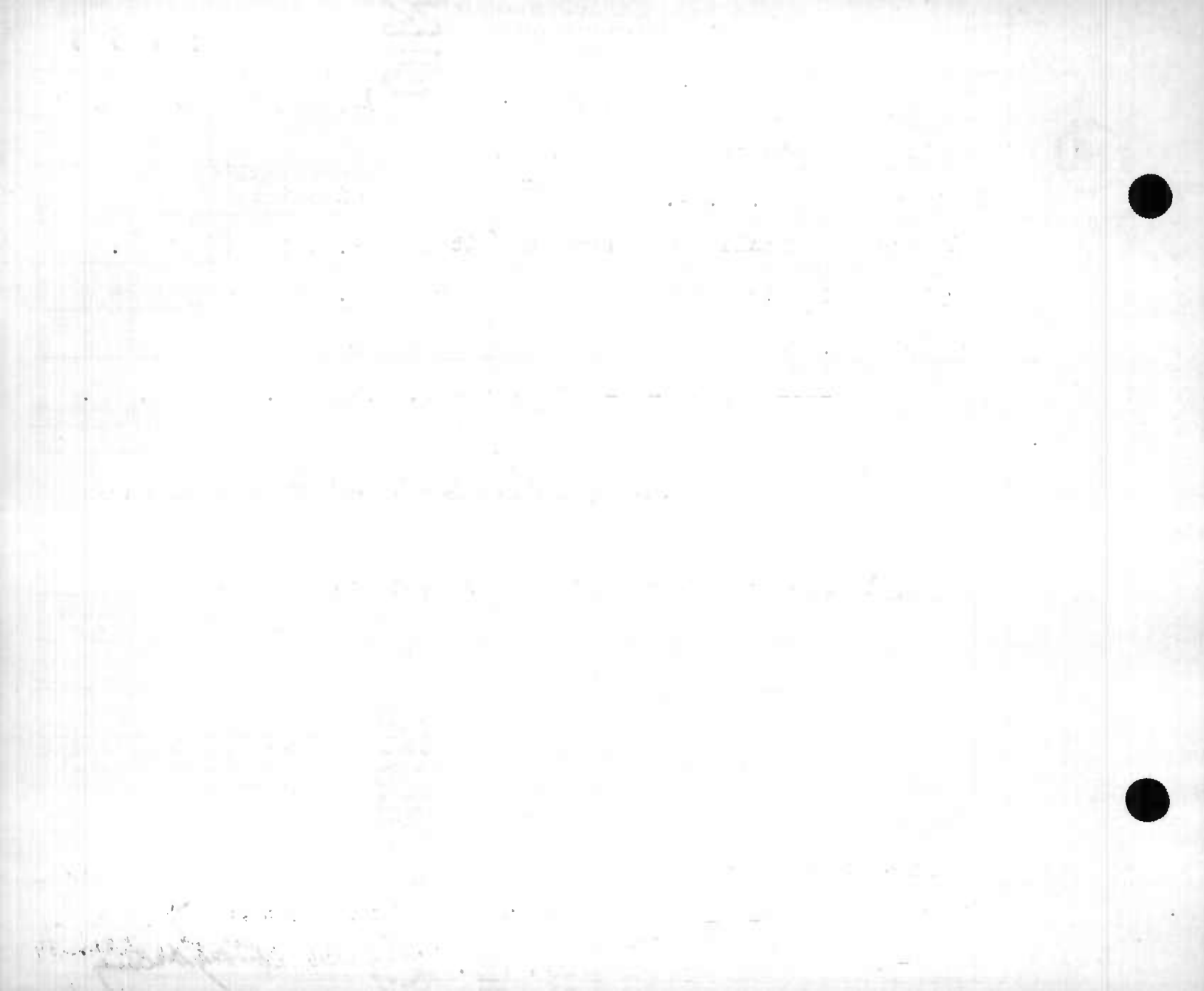
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8002659									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN	
Edythe Dorothy						BEHEN		JANUARY 9 1980		6 35 PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		Nov. 28, 1912		67 YRS		2 11			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Indiana		U. S. A.				Wicomico MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						Ret. Union Trust Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS	
Maryland		Wicomico		Delmar				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #3 Foskey Lane	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Frederick E. Granger		Mary Beachler									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		180-24-0397		James J. Behen Jr. Delmar, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>cardiac arrhythmia</u>										min	
4140 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										4 yr	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>chronic obstructive lung disease, severe</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>69</u> , to <u>Jan</u> , 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>Jan 9</u> , 19 <u>80</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.											
22a. SIGNATURE		DEGREE						22c. DATE SIGNED			
<u>John T. Bulkeley M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						1-10-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
JOHN T. BULKELEY		S. SALISBURY BLVD., SALISBURY MD 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1-12-1980		Holy Cross		Dover Kent Delaware					
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Marvel-Short Funeral Home		Jan 4 1980		<u>John T. Bulkeley</u>							
Delmar, Del.											

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8002660			
1. DECEASED NAME (TYPE OR PRINT) Arabella W. Bivens				2a. DATE OF DEATH MONTH DAY YEAR January 31, 1980			
3 SEX F				2b. HOUR 8:00 P.M.			
4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4 9 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
12. CITY OR TOWN OF DEATH Salisbury		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		15. KIND OF BUSINESS OR INDUSTRY Sea Food	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Sam. 13c. CITY OR TOWN Marion		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS c/o P.O. Marion Md.			
19. FATHER'S NAME FIRST MIDDLE LAST Henry Whittington		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Handy		21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		22. SOCIAL SECURITY NO 213-16-7050	
23. INFORMANT ADDRESS William Bivens - Marion Md.		24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiogenic Shock		25. DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction		26. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease	
27. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Myocardial Infarction		28. DATE OF OPERATION 4/10		29. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
31. DATE OF OPERATION		32. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		34. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
35. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE			
38. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		39. I certify that (1) (this hospital) attended the deceased from 4/25 19 80 to 4/31 19 80 , that (1) (we) last saw the deceased alive on 4/31 19 80 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.		40. SIGNATURE Arnold M. Wood MD		41. DATE SIGNED 4/31/80	
42. PHYSICIAN'S NAME (TYPE OR PRINT) D. M. Wood		43. ADDRESS P.O. H.		44. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
45. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		46. DATE 1/4/80		47. NAME OF CEMETERY OR CREMATORY Ebenezer		48. LOCATION CITY OR TOWN COUNTY STATE Marumscod Md.	
49. FUNERAL DIRECTOR NAME Anthony E. Wood		50. ADDRESS Crispfield Md.		51. DATE REC'D. BY REGISTRAR FEB 5 1980		52. REGISTRAR'S SIGNATURE Rickie K. K...	

602

January 31, 1980

Witness

Bolesburg Tennessee General Hospital Laborer

Mr. Stan. Wilson
Mr. William M. Williams
Mr. William M. Williams

Mr. William M. Williams
Mr. William M. Williams
Mr. William M. Williams

Mr. William M. Williams
Mr. William M. Williams
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Mr. William M. Williams

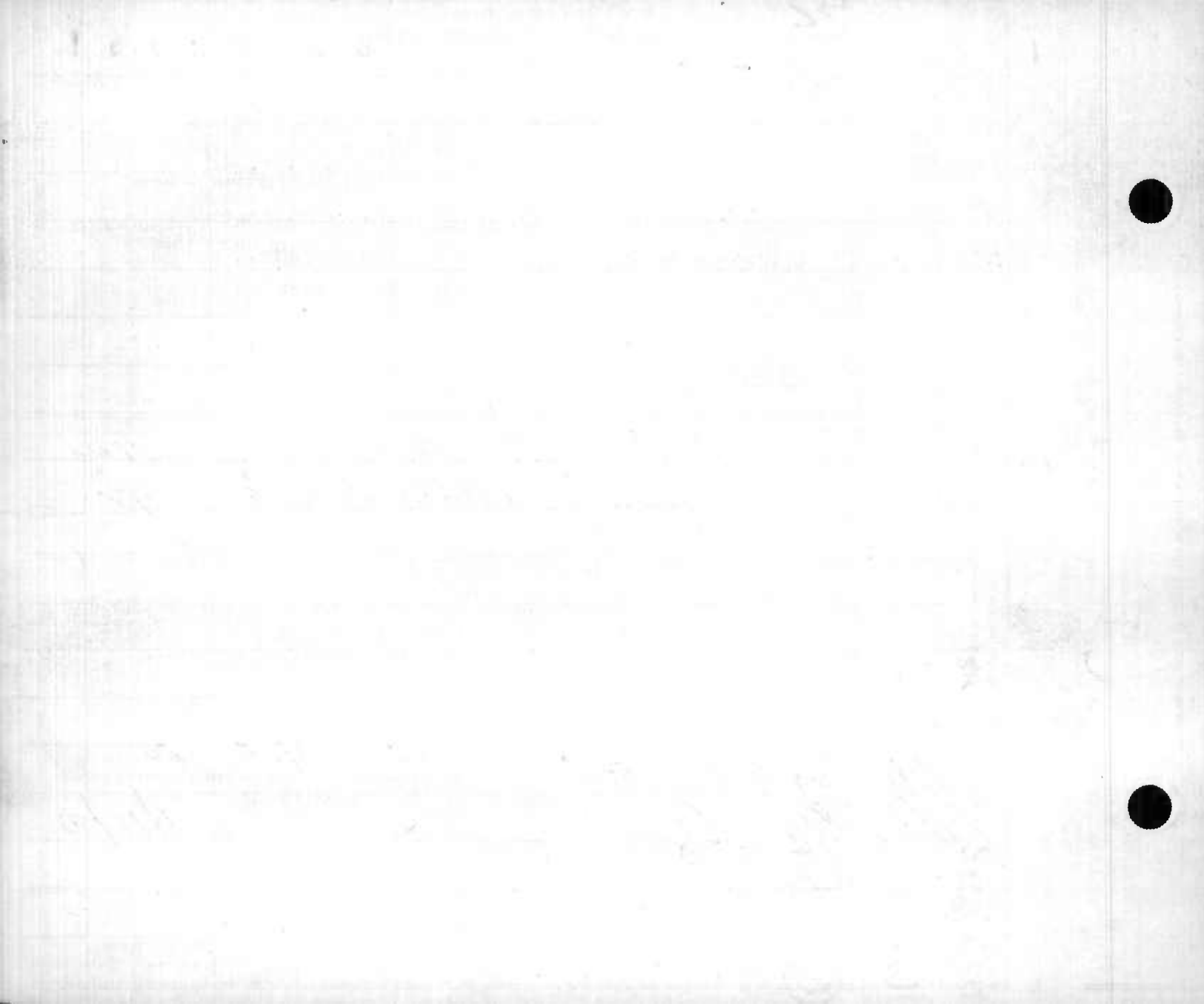
Mr. William M. Williams
Mr. William M. Williams
Mr. William M. Williams

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002661			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida Ray BOUNDS					2a. DATE OF DEATH MONTH DAY YEAR 1-18-80				2b. HOUR 4:15 AM				
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11-11-91		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 88 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none					
13a. STATE Maryland					13b. COUNTY Wicomico		13c. CITY OR TOWN Fruitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Theo Parsons Nicholson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Marvel								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-0997		17. INFORMANT ADDRESS same as 13 Mrs. Alice Bounds (daughter-in-law)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arterial thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized atherosclerosis</u> (c) <u>Generalized atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>yes</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>previous arterial thrombosis</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17/80</u> to <u>1/18/80</u> , that (I) (we) lost <u>1/17/80</u> saw the deceased alive on <u>1/17/80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Earl M. Beardsley</u> DEGREE					22c. DATE SIGNED <u>1/18/80</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.					22e. ADDRESS Rt. 50 & Civic Ave, Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/1980		23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR JAN 23 1980		25b. REGISTRAR'S SIGNATURE <u>Barney McCreedy</u>						

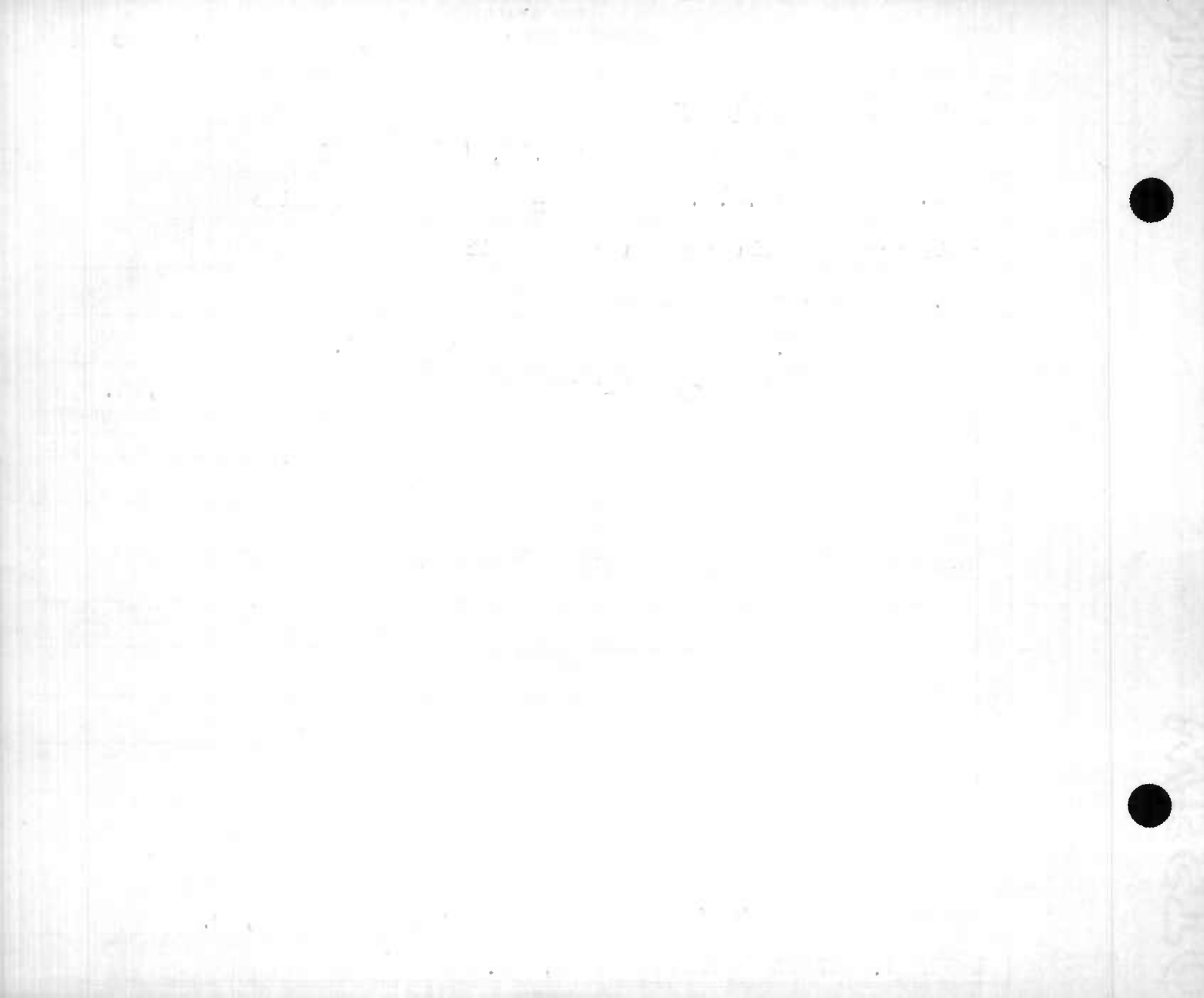


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8002662							
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
RALPH B. Bounds				Jan 25, 1980		6:43 P		M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		AUG. 25, 1896		83 YRS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MD.		U.S.A.				Wicomico MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				RETIRED			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD.		WICOMICO		ALLEN					
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
EDWARD G. BOUNDS				MARY C. PUSEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
YES				WAR 11		218-14-4581 CARROLL BOUNDS SALISBURY, MD.			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumococcal meningitis									
486- DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonitis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 23, 19 80 to Jan 25, 19 80, that (I) (we) last saw the deceased alive on Jan 25, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
John G. Bullseye M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1-25-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		1/28/80		ALLEN CEMETERY		ALLEN, MD.			
24 FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LEVIN R. WILSON				PRINCESS ANNE, MD.		JAN 31 1980			



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8002663			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA Marie Bowden				2b. HOUR 8 1/2 M			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR Oct. 20 1917		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WTCOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Worcester Berlin				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 2, Box 178	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Hall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie - Pointer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 215-18-4213		17. INFORMANT ADDRESS Joshua T. Bowden, Rt. 2, Box 178, Berlin, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1889 METASTATIC CARCINOMA OF BLADDER DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS; CHRONIC PULMONARY DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from MAY 19 79, to JANUARY 28, 19 80, that (1) (we) lost saw the deceased alive on JANUARY 28, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.							
22b. SIGNATURE John A. Shenasky MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/28/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN H. SHENASKY MD				22e. ADDRESS 16 MEDICAL CENTER, SALISBURY, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/80		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Wor. Md.	
24. FUNERAL DIRECTOR NAME Anna A. Bulbaga ADDRESS 108 Williams St. Berlin Md.				25a. DATE REC'D. BY REGISTRAR FEB 5 1980		25b. REGISTRAR'S SIGNATURE Mary McCreedy	

BP

DHMH-16 20M
(VRA 15, 4) 7/78

5170

1941



W. A. ...



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DHMM-16 20M
(VRA 15, 4) 7/78

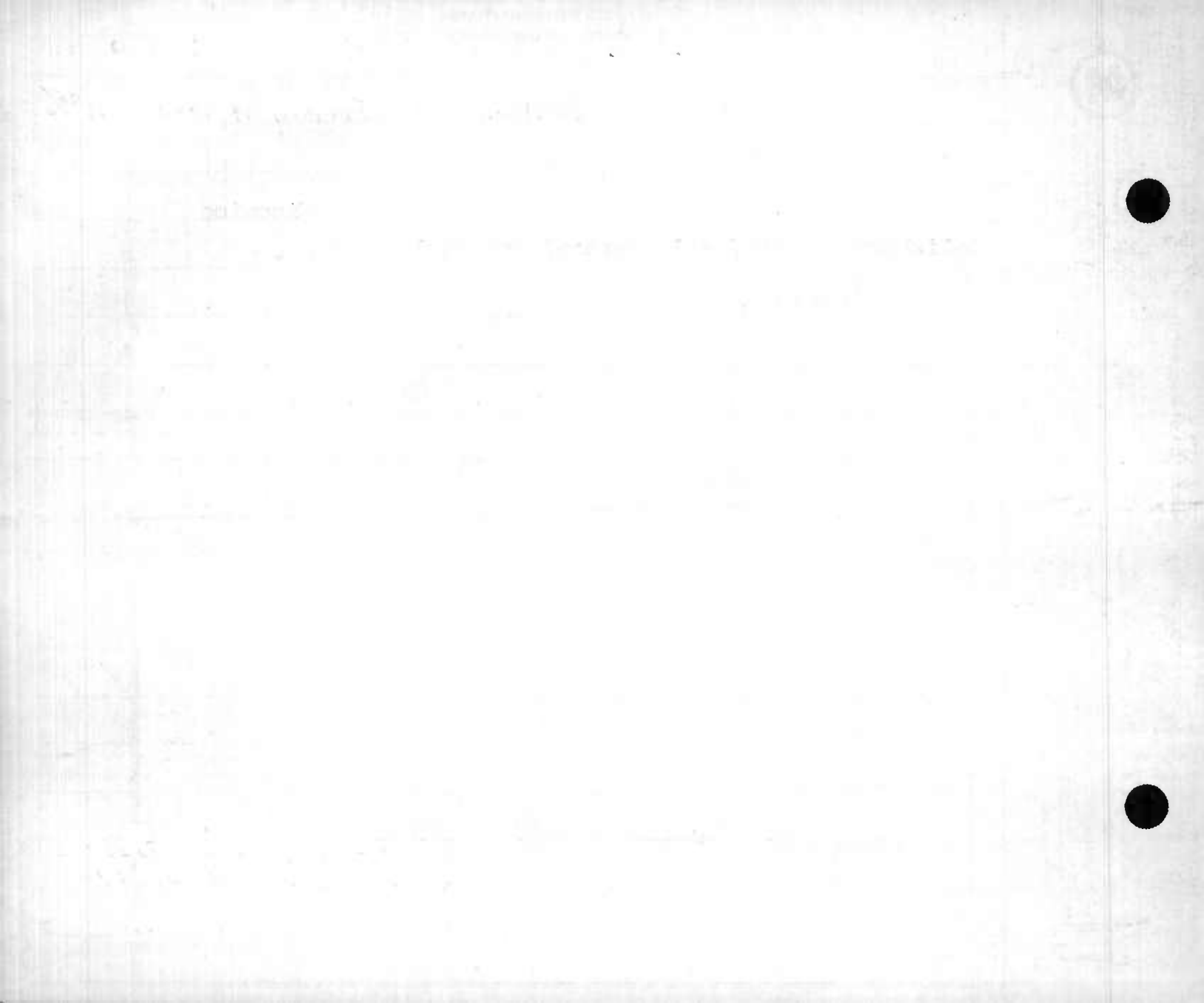
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 0 2 6 6 4

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR		
1 DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		11 05 P M		
FIRST MIDDLE LAST		January 19, 1980				
MATTIE HESTER Bratten						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7 UNDER 1 YEAR		
Female	White	MONTH DAY YEAR	82 YRS	8 UNDER 24 HRS		
		Aug. 4, 1897				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	9 BALTIMORE CITY OR COUNTY OF DEATH				
Pittsville, Md. USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Wicomico MD.				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury	Peninsula General Hospital	Housewife		none		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a STATE	13b CITY OR TOWN	13c INSIDE CITY LIMITS?	13d STREET ADDRESS			
Maryland	Wicomico	Pittsville	YES <input type="checkbox"/> NO <input type="checkbox"/>	Railroad Ave., Box 224		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST			FIRST MIDDLE LAST			
Fred Parker			May Belle Campbell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT (daughter) ADDRESS		
No		217-36-1484		Mrs. Mabel M. Moore, Esham Road, Parsonsburg, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY						
IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u>						
1749						
DUE TO, OR AS A CONSEQUENCE OF						
(b) <u>Breast Cancer with lung metastasis</u>						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
		P.M. 19				
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>1/19/80</u> 19 <u>80</u> , to <u>1/19</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/19/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b SIGNATURE		DEGREE		22c DATE SIGNED		
<u>Joseph P. Grasso MD</u>		MD		1/21/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				
Joseph P. GRASSO		SOUTH DIVISION STREET EXT SALISBURY MD. 21801				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		
Burial		1/22/80		Wicomico Mem. Park		
24 FUNERAL DIRECTOR		24a ADDRESS		25a DATE REC'D. BY REGISTRAR		
HOLMWAY Funeral Home, Salisbury, Md.				JAN 23 1980		
				25b REGISTRAR'S SIGNATURE		
				<u>[Signature]</u>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP _____

DHMM-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		80 02665 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Jane O. Brewer				2a. DATE OF DEATH MONTH DAY YEAR 1-11-80				3b. HOUR 8:00 A.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11-17-92		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chester, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Carolina		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Academy Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST William Dunbar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hunter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mrs. Margaret Nichols, Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>pneumonitis [Staph aureus]</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b): <u>aspirin</u> (c): <u>Advanced A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph C. Fitzgerald M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH C. FITZGERALD, M.D.				22e. ADDRESS South Bldg Medical Center, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-15-80		23c. NAME OF CEMETERY OR CREMATORY Whitemarsh Cemetery		23d. LOCATION CITY OR TOWN Prospectville, Pa.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME H. H. Baker				ADDRESS Federalsburg, Md.		25a. DATE REC'D. BY REGISTRAR JAN 21 1980		25b. REGISTRAR'S SIGNATURE History McLeod	

MEDICAL CERTIFICATION

for (refuse)

for (refuse)

for (refuse)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0002666									
1 DECEASED NAME (TYPE OR PRINT) Queenie Esther BRITTINGHAM					2a. DATE OF DEATH MONTH DAY YEAR January 4, 1980			2b. HOUR P M 7:35			
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1927		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Upsbur					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luzetta Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 231-32-9113		17. INFORMANT Terry Brittingham		ADDRESS 656 Cedar St. Pocomoke, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 metastatic carcinoma of ovaries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1978		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1/29 to 1/4/80, that (I) (we) last saw the deceased alive on 1/4 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Inja Joe Hwang, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/4/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja Joe Hwang, M.D.						22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (IFY) Burial			23b. DATE 1-12-80		23c. NAME OF CEMETERY OR CREMATORY St. James Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Wor. Md.				
24. FUNERAL DIRECTOR NAME Samuel H. Sawyer						ADDRESS New Church, Va.		25a. DATE REC'D. BY REGISTRAR JAN 14 1980		25b. REGISTRAR'S SIGNATURE Petry, K. Brady	

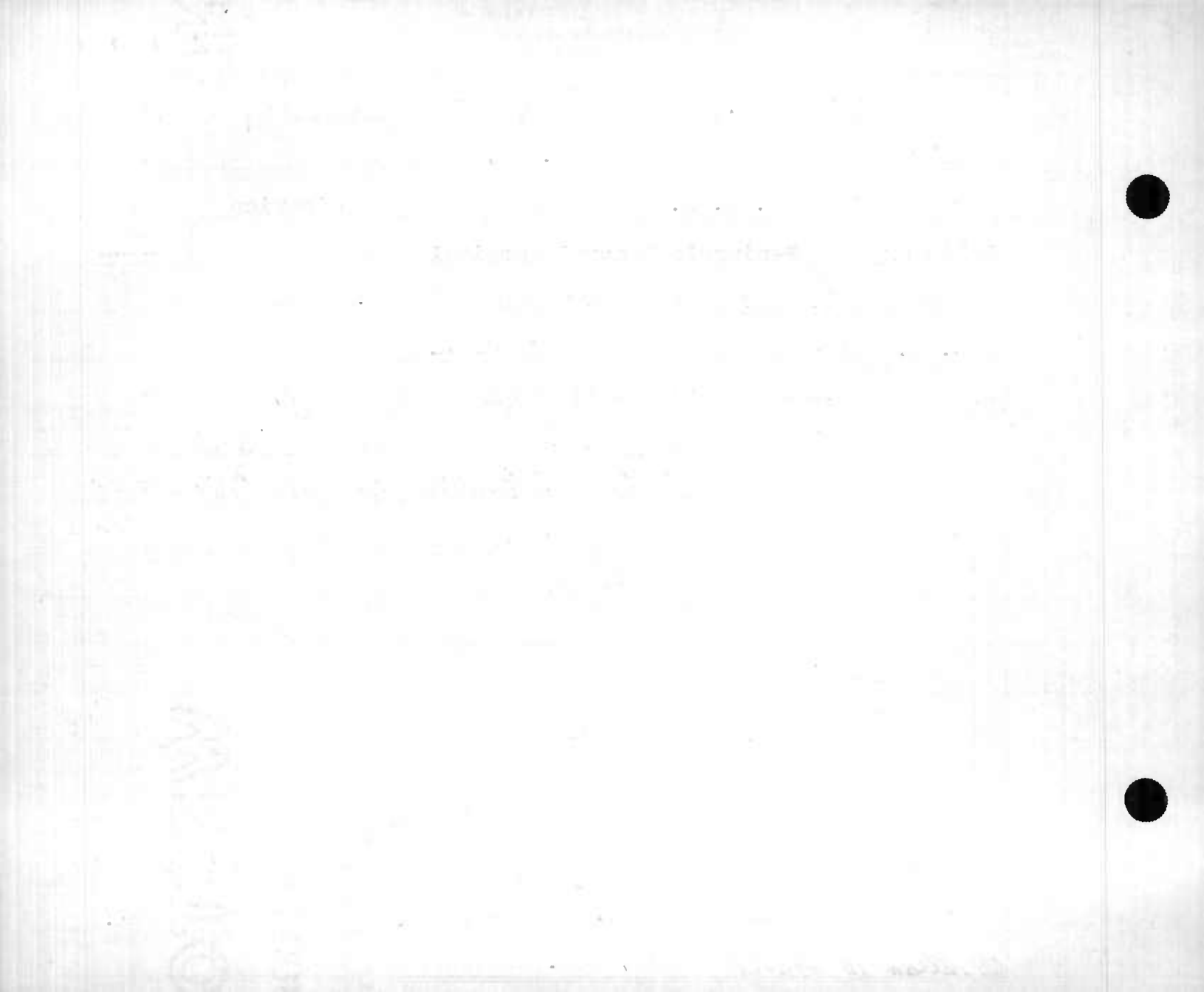
BP

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 0 2 6 6 7	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Lillian M. BRYANT			2a. DATE OF DEATH MONTH DAY YEAR January 28, 1980			2b. HOUR 8:10 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS 11 DAYS 12		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury		
14. FATHER'S NAME FIRST MIDDLE LAST Ira. E. Phillips			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Enola M. LeCates			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Pemberton Manor		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 079-03-5011			17. INFORMANT ADDRESS Paul Baker Dover, Delaware					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) <u>Respiratory Failure - Chronic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Suppurative CVD Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Osteo-Arthritis</u>											
19a. DATE OF OPERATION 0			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Wicomico Md					
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1978</u> to <u>Jan 28, 1980</u> , that (I) (we) lost saw the deceased alive on <u>Jan 28, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE Herbert Sembly MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/28/80		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) G. Herbert Sembly MD						22d. ADDRESS Salisbury Md 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-31-1980			23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Del.		
24. FUNERAL DIRECTOR NAME William M. Shortz						ADDRESS Delmar, Del. 19940			25a. DATE REC'D. BY REGISTRAR FEB 1 1980		
						25b. REGISTRAR'S SIGNATURE					



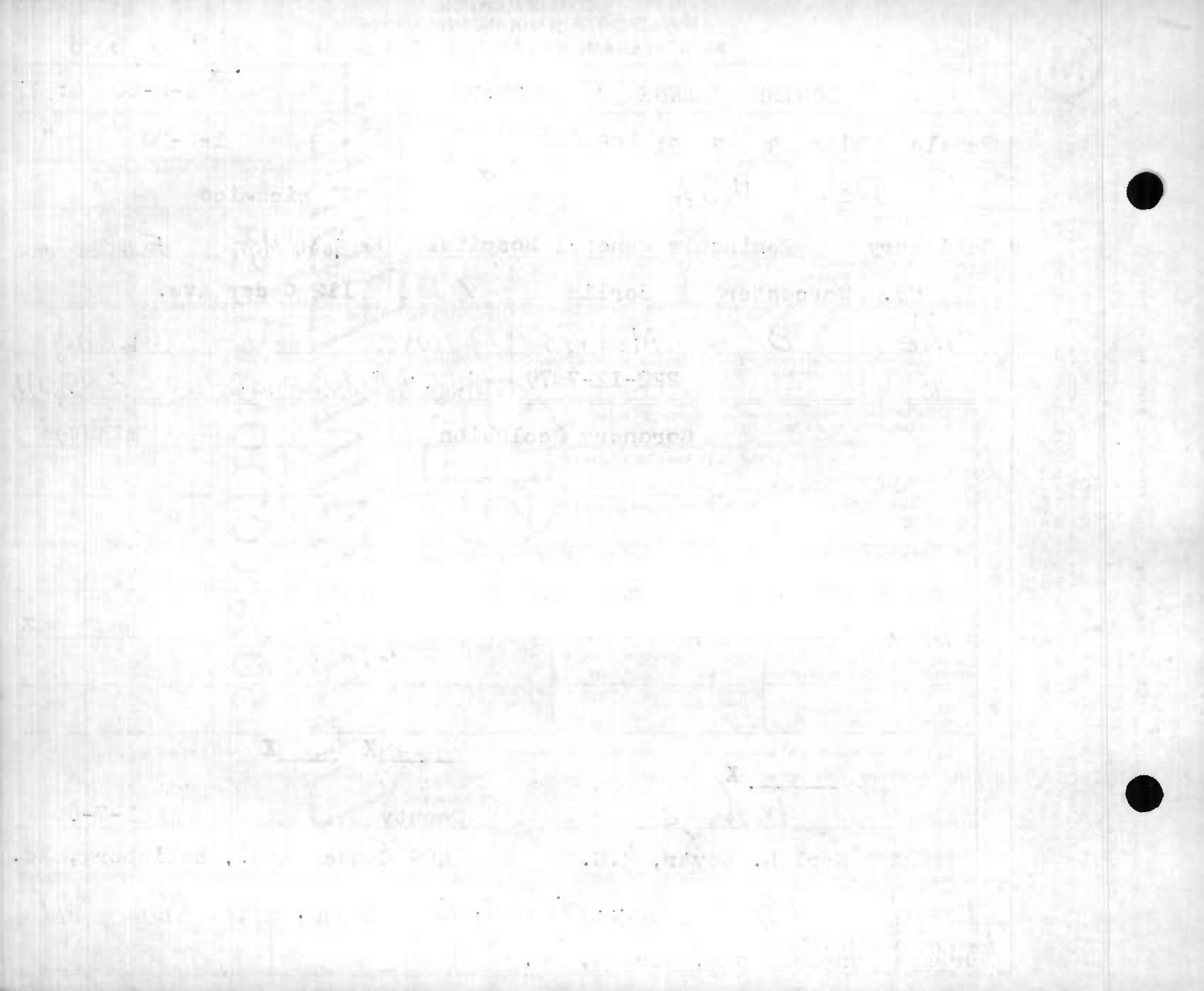
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 6 6 8

1- STATE REGISTRAR		FOR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		STATE OF MARYLAND	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
LOUISE		ANNE		BURBAGE			
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. DATE KNOWN OF DEATH	7b. HOUR
Female	White	MONTH DAY YEAR	YRS.	MONTHS DAYS	HOURS MIN	1-6-80	6:37P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Del.	U.S.A.			Wicomico			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury	Peninsula General Hospital		Restaurant Mgr.		Food Beverage		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md.	Worcester	Berlin	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	112 Cedar Ave.			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME						
First Middle Last	First Middle Last						
Ollie B. Morris	Laura - Long						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS					
No	222-12-7879	William W. Burbage, 112 Cedar Ave., Berlin, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							minutes
IMMEDIATE CAUSE (a) Coronary Occlusion							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Earl L. Royer, M.D.		Deputy MEDICAL EXAMINER		1-7-80			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		1/9/80		Sunset Memorial Park		CITY OR TOWN COUNTY STATE	
						Berlin RFD. Wor. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Anna R. Burbage		108 Williams St.		JAN 11 1980		History McCreedy	
Burbage Funeral Home, Berlin, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 21 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 00020669			
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY S. MIDDLE LAST CARTER				2a. DATE OF DEATH MONTH DAY YEAR 1-5-80				2b. HOUR MIN 11 A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6-12-86		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY WICOMICO		13c. CITY OR TOWN BERLIN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS MAIN ST.	
14. FATHER'S NAME FIRST MIDDLE LAST MORGAN STEPHEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRYN STEPHEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-34-8215		17. INFORMANT ADDRESS RUTH C. HOLLAND, BERLIN MD.					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 } DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure } (c) Coronary Artery Sclerosis } Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) old Fract w/ f from 1973											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-26 19 23, to 1-5 19 80, that (I) (we) lost saw the deceased alive on 12-26 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. C. Mitchell				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/7/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Mitchell				22e. ADDRESS POB 2378 Salisbury, Md 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-7-80		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WICOMICO MD.					
24. FUNERAL DIRECTOR NAME ULRICH FUNERAL HOME				ADDRESS BERLIN, MD.		25a. JAN 10 1980		25b. REGISTERED			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02670	
1. DECEASED NAME (TYPE OR PRINT) JAMES LESTER CARTWRIGHT										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1-4-80	
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 12 12 18 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2b. DATE PRONOUNCED DEAD 1-4-80 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent-Canned & Frozen Food	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1963 Pineway											
14. FATHER'S NAME FIRST MIDDLE LAST Levi Hanley Cartwright 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Corlan Gross											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II 16b. SOCIAL SECURITY NO. 212-10-9134 17. INFORMANT ADDRESS Mrs. Mary M. Cartwright (wife) same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Acute Pulmonary Edema IMMEDIATE CAUSE (a) 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1-4-80											
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 1/7/80 23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic. Maryland											
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME ADDRESS Salisbury, Md. 25a. D. BY REGISTRAR JAN 9 1980 25b. REGISTRAR'S SIGNATURE [Signature]											

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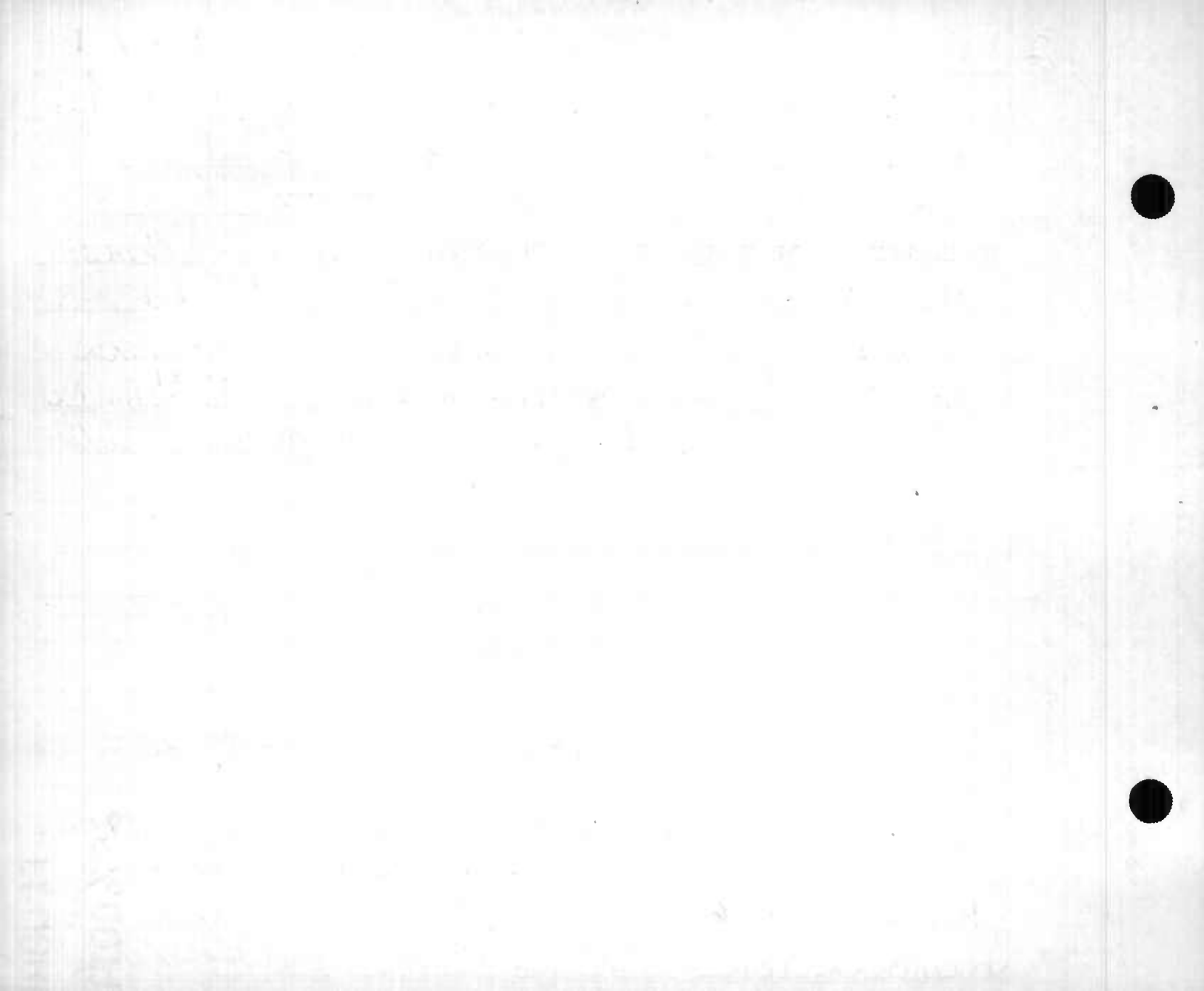
Figure 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002671			
1. DECEASED NAME (TYPE OR PRINT) ADA FRANCES Collick										2a. DATE OF DEATH MONTH January DAY 19 YEAR 1980		2b. HOUR 10 P.M.	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.							
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housekeeper		12b. KIND OF BUSINESS OR INDUSTRY domestic					
13a. STATE Md.				13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Snow Hill, Md			
14. FATHER'S NAME FIRST William MIDDLE LAST Pitts				15. MOTHER'S MAIDEN NAME FIRST Nancy MIDDLE LAST Johnson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-30-8802		17. INFORMANT Betty Townsend				ADDRESS Rt. #1 Snow Hill, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) arterio sclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) arterio Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arterio DUE TO, OR AS A CONSEQUENCE OF (c) arterio PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH arterio			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-18 19 80 , to 1-19 19 80 , that (I) (we) last saw the deceased alive on 1-19 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Walter R. Ellis DEGREE MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-19-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILBER R. ELLIS						22e. ADDRESS KAY DR. SALISBURY MD 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-26-80		23c. NAME OF CEMETERY OR CREMATORY Mt. Wesley U.M. Cemetery		23d. LOCATION CITY OR TOWN Snow Hill COUNTY Worcester STATE Md						
24. FUNERAL DIRECTOR NAME JOLEY MEMORIAL Chapel						ADDRESS Rt. #2 Jersey Rd. SAUS. Md.		25a. DATE REC'D. BY REGISTRAR JAN 23 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

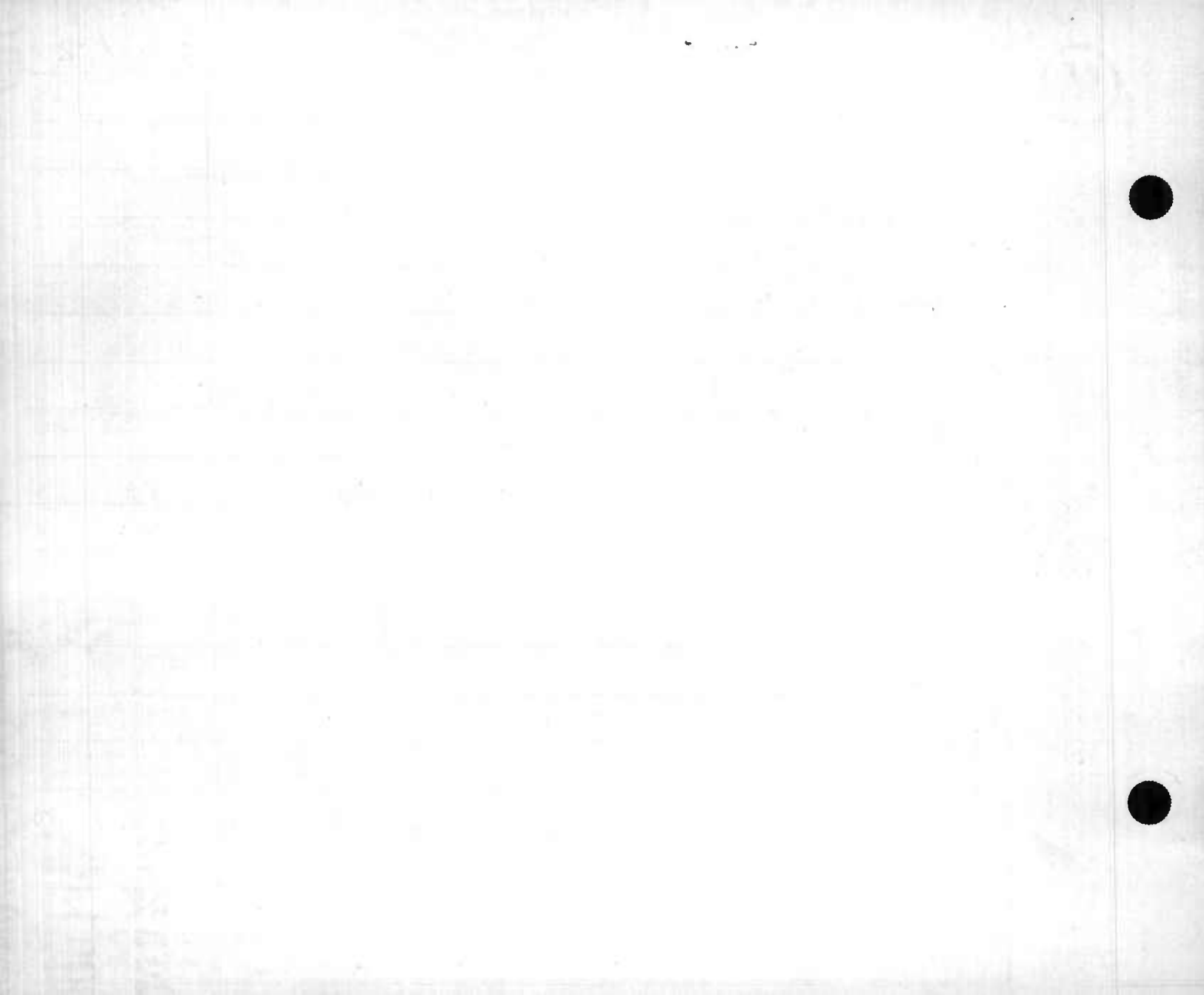
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(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 6 7 2
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN Frances COOK			2a. DATE OF DEATH MONTH DAY YEAR 1 16 1980			2b. HOUR P M 6:15 P M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Danville, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.				
10 CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr. Georges		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 404 Cedar Ridge Drive	
14 FATHER'S NAME FIRST MIDDLE LAST Frank A. Gourley			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dollie Willis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 228-24-9794		17 INFORMANT (daughter) ADDRESS Mrs. Beverly Smith, Rt. 1, Box 411 Chester, Md.					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1st Partur</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetic Mellitus</u> (c) <u>ASCD.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph C. Fitzgerald</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-17-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph C. Fitzgerald, M.D.			22e. ADDRESS Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/80		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.		23d. LOCATION CITY OR TOWN Danville		COUNTY STATE Virginia		
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, ADDRESS Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR JAN 21 1980		25b. REGISTRAR'S SIGNATURE <u>Pinkney McCready</u>					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0

REG. NO. 0 2 6 7 3

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gordon Lee Cooper</i>			2a DATE OF DEATH MONTH DAY YEAR <i>Jan 26, 1980</i>		2b HOUR <i>7AM</i>
3 SEX <i>MALE</i>	4 RACE <i>WHITE</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>JAN 3, 1884</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>96</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR COUNTRY) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>Wilcomie</i> MD.		
10 CITY OR TOWN OF DEATH <i>PARSONSBURG</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>RT #346</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>FARMER Ret</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Md.</i>			13b COUNTY <i>Wilcomie</i>		13c CITY OR TOWN <i>PARSONSBURG</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>Ned Cooper</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Davis</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>214-32-6809</i>		17 INFORMANT ADDRESS <i>Dorothy Dunstan Willards Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>496 -</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Lung Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i> <i>years.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 10, 1980</i> to <i>Jan. 18, 1980</i> , that (I) (we) last saw the deceased alive on <i>Jan. 18, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Allen H. Dunstan, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Jan. 28, 1980</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen W. TUSTIN</i>		22e. ADDRESS <i>209 Maryland Ave., Salisbury, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>1-28-1980</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Willards, Cern.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Willards Md.</i>	
24. FUNERAL DIRECTOR NAME <i>H. H. Baker-Bounds, Salisbury, Md.</i>		ADDRESS <i>Salisbury, Md.</i>		25. DATE REC'D. BY REGISTRAR <i>FEB 8 1980</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

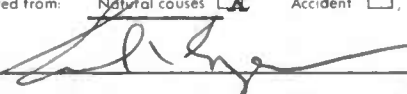
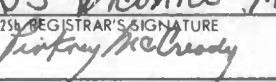
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

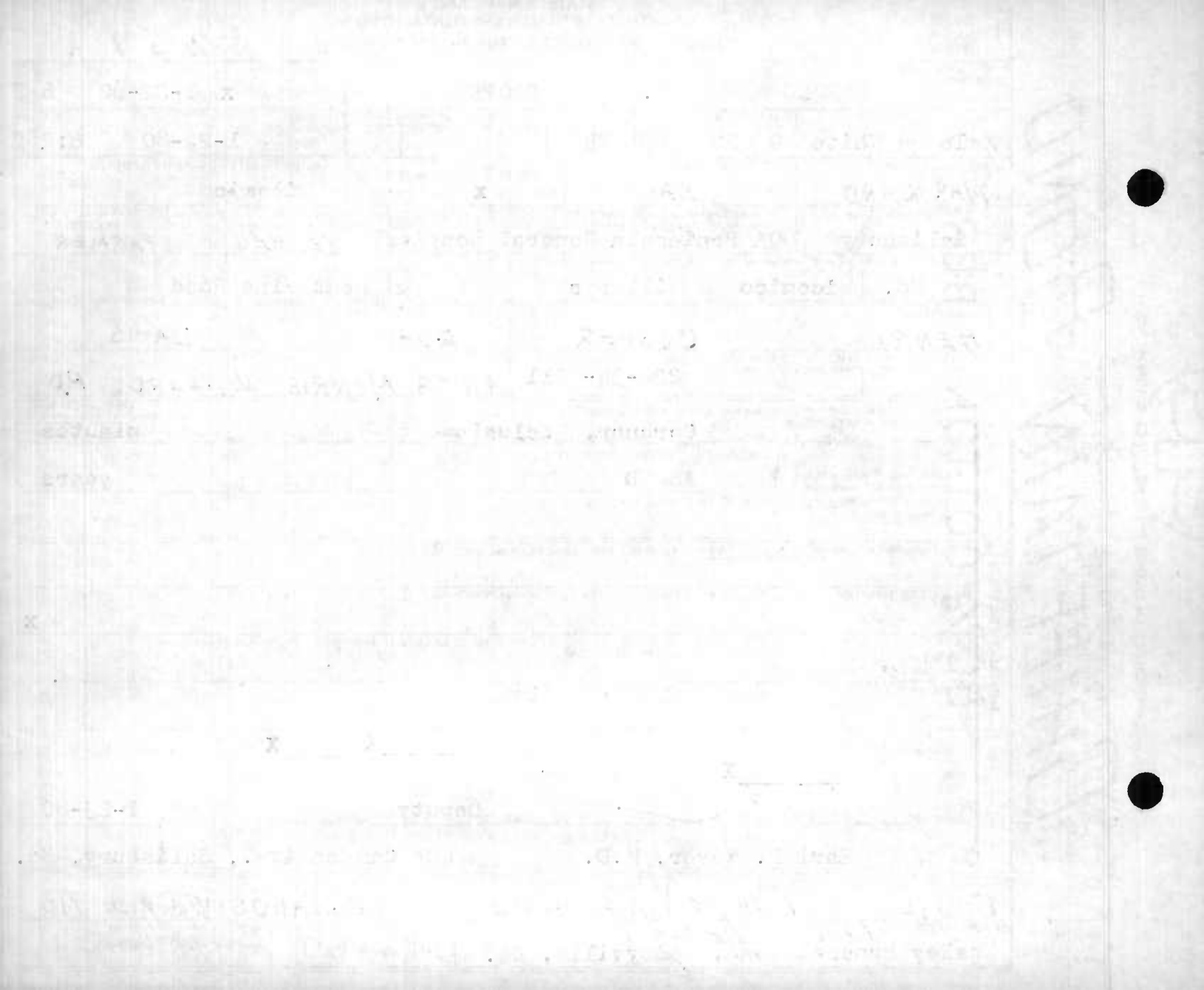
Page 1 of 2. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D NO. 02674			
1. DECEASED NAME (TYPE OR PRINT) HAROLD B. COOPER										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 1-22-80		2b. HOUR 6 P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 28 YEAR 05		6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY FARMER.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Willards		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bent Pine Road					
14. FATHER'S NAME FIRST HENRY MIDDLE COOPER LAST COOPER						15. MOTHER'S MAIDEN NAME FIRST EVA MIDDLE DAVIS LAST DAVIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 220-34-9211		17. INFORMANT ADDRESS ANITA MORRIS WILLARDS, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy M.D.				DATE SIGNED 1-23-80					
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (CFR) BURIAL				23b. DATE 1-24-80		23c. NAME OF CEMETERY OR CREMATORY NEW HOPE		23d. LOCATION CITY OR TOWN COUNTY STATE WILLARDS WICOMICO MD.					
24. FUNERAL DIRECTOR NAME Whaley Funeral Home, Seabysville, De.						25a. DATE REC'D. BY REGISTRAR JAN 28 1980		25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 0 2 6 7 5					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herman W CROSSWELL					2a. DATE OF DEATH MONTH DAY YEAR January 20, 1980				2b. HOUR P M 10:20 P M		
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 10 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.		7b. CITIZEN OF WHAT COUNTRY? MD.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wilcomi co MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY SEA Food			
13a. STATE MD		13b. COUNTY Som.		13c. CITY OR TOWN MARION		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rural - G.D.			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK CROSSWELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary MOORE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Dorethia Cottingham			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neurological ds of undetermined etiology. organ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M Shrestha				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/20/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/26/80		23c. NAME OF CEMETERY OR CREMATORY John WESLEY		23d. LOCATION CITY OR TOWN COUNTY STATE WESLEY MD.		25a. DATE REC'D. BY REGISTRAR JAN 25 1980			
24. FUNERAL DIRECTOR NAME Anthony E. Ward				ADDRESS Crisfield MD.		25b. REGISTRAR'S SIGNATURE Anthony E. Ward					

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHAM - 17
(VR A15 ME (51))
30M 7/73

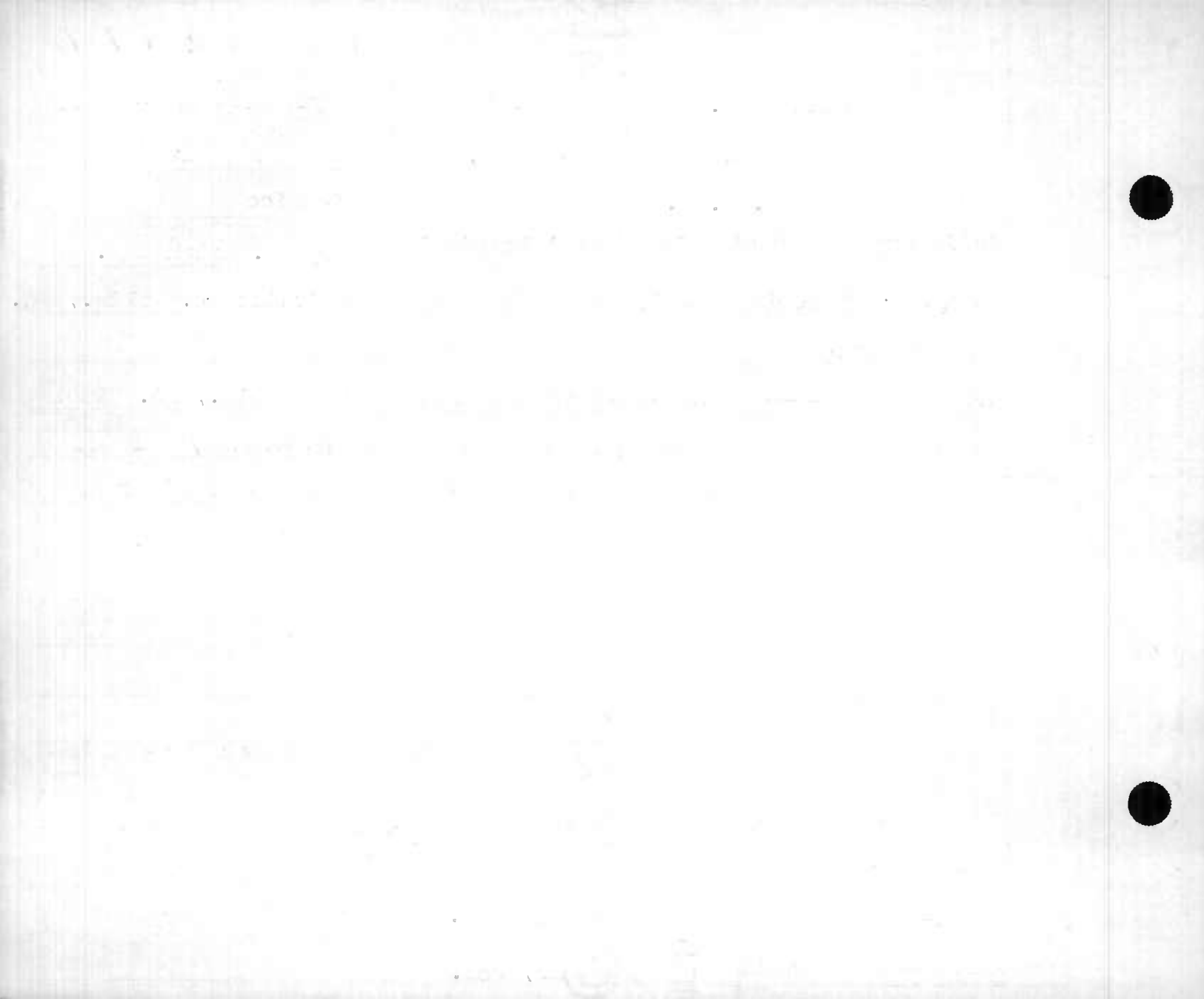
FOR 1- STATE REGISTRAR												STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 02676			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST RUTH MAE DASHIELL						2a. DATE KNOWN OF DEATH ESTIMATED 1-6-80						2b. HOUR A.M.									
3. SEX Female		4. RACE AA		5. DATE OF BIRTH MONTH DAY YEAR 5 15 01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 1-6-80 19 6:33A						2d. HOUR A.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md						7b. CITIZEN OF WHAT COUNTRY? U.S.						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.									
10. CITY OR TOWN OF DEATH Salisbury						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed						12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md.						13b. COUNTY Wicomico		13c. CITY OR TOWN Nanticoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS General Delivery															
14. FATHER'S NAME FIRST MIDDLE LAST George W. W. Dashiell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lucinda Hall																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 215-14-3702						17. INFORMANT Charlotte Peters, Tyaskin Md															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 410- } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } <u>ASCVD</u> (b) } (c) } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE						TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						DATE SIGNED 1-7-80															
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.						ADDRESS 409 Camden Ave., Salisbury, Md.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 1/13/80						23c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.						23d. LOCATION Tyaskin, Md. COUNTY STATE									
24. FUNERAL DIRECTOR NAME Messick Funeral Home, Bivalve, Md.						25a. DATE REC'D. BY REGISTRAR JAN 9 1980						25b. REGISTRAR'S SIGNATURE R. J. McNamee															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR		REG. NO. 8002677									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Keith Dwight		DEAN						JANUARY 24, 1980		2:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
Male		White		March 15, 1936		43 YRS		10 9			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Indiana		U. S. A.				Wicomico MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						George L. Ralph Inc.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS	
Maryland		Wicomico		Salisbury				YES		331 Truitt St. Salis., Md.	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Bernal Dean		Opal Powell									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
no		222-24-8419		Joyce Ann Dean		Salis., Md. 21801					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRANSIENT CEREBRAL HERNIATION</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MALIGNANT HYPERTENSION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 5 HOURS YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>80</u> , to <u>1-24</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>1-24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Richard E. Bird M.D.						1-24-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Richard E. Bird M.D.		233 Florida Ave, Salisbury, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1-27-1980		Riverside Cem.		Powellville Maryland					
24 FUNERAL DIRECTOR NAME		24b DATE REC'D. BY REGISTRAR		24c REGISTRAR'S SIGNATURE							
William M. Short		JAN 31 1980		H. J. McCreedy							
Marvel-Short Funeral Home		Delmar, Del.									



TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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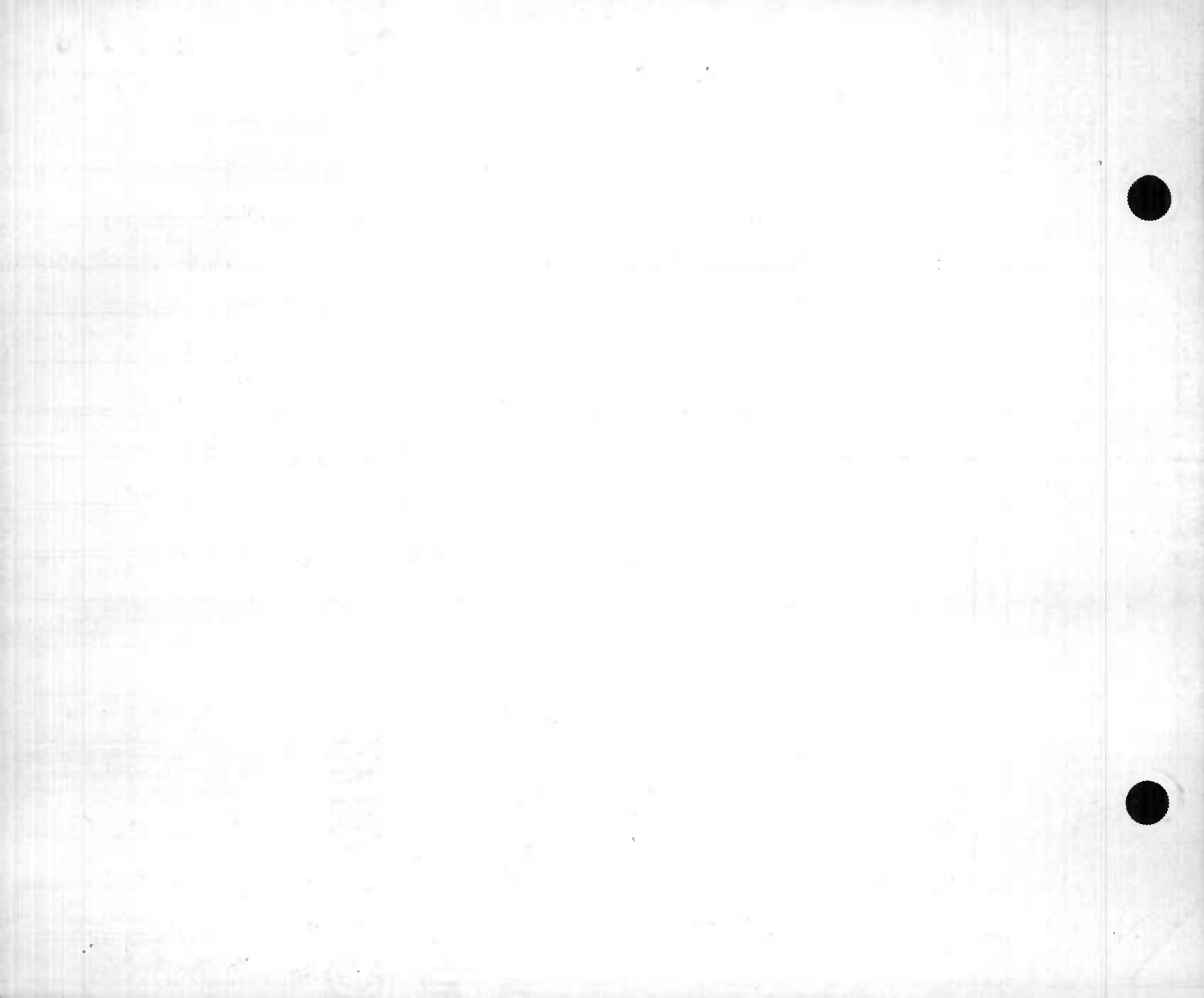
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 6 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maggie Gertrude Dennis			2a. DATE OF DEATH MONTH DAY YEAR 1-11-80			2b. HOUR 3:05 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2-28-99		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife & Seamstress-Shirt Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Hebron		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Church Street	
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Brumbley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Dryden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-7767D		17. INFORMANT (daughter) Mrs. Laura Johnson, Hebron, Md.		ADDRESS Box 411			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left hemiparesis</u> 3429 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.U.D.</u> (c) <u>yes.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph C. Fitzgerald M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSEPH C. FITZGERALD				22e. ADDRESS Medical Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/80		23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hebron, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 16 1980		25b. REGISTRAR'S SIGNATURE Lester A. Brady	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

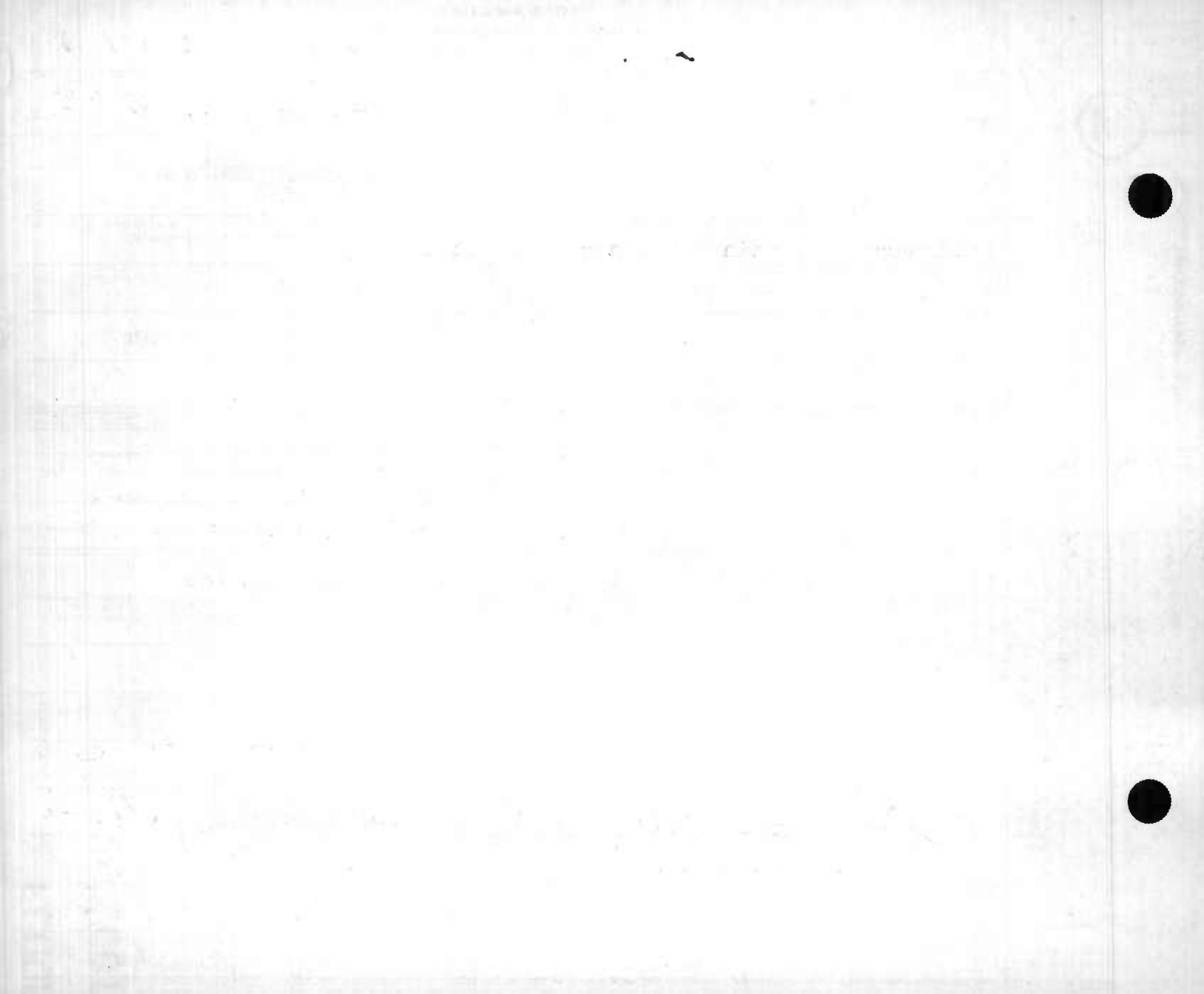
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 02679	
1. FOR STATE REGISTRAR		1a DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NETTIE ELLEN DIXON				2a DATE OF DEATH MONTH DAY YEAR JANUARY 24 1980			2b HOUR 9 1/2 M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 UNDER 1 YEAR MONTHS DAYS		7b UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Laurel, Del.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY none		
13a STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 414 Bethel Street			
14 FATHER'S NAME FIRST MIDDLE LAST Hammond				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie LeCates							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-1747		17 INFORMANT (son) Mr. Carroll Lee Dixon, Jr.,		ADDRESS 29 Nanticoke Circle Drive Seaford, Del.					
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure 4409 DUE TO, OR AS A CONSEQUENCE OF (b) bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Probable bronchogenic tumor - diabetes											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) [this hospital] attended the deceased from 1-20 1980 to 1-24 1980, that (II) (we) lost saw the deceased alive on 1-24 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) (did) (did not) view the body after death.											
22b SIGNATURE John T. Bulkeley M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1-26-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.				22e ADDRESS Salisbury, Md.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1/26/80		23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico, Maryland					
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland				25a DATE REC'D. BY REGISTRAR JAN 28 1980		25b REGISTRAR'S SIGNATURE [Signature]					

BP

DHMM-16 20M
(VRA 15, 4) 7/78



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 6 8 0

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) MARY W. DOWNES		7a. DATE OF DEATH MONTH DAY YEAR JAN. 1, 1980		7b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 23, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SALISBURY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE WILSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE HASTING		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 215-20-4892		17. INFORMANT ADDRESS MRS MARGARET SMITH WILDMAN ARMS SWARTHMORE, PA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized atherosclerosis (c) yes. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 78 , to 1/1 , 19 80 , that (I) (we) last saw the deceased alive on 12/31 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Shirley		DEGREE MD		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 1/2/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/3/80		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY, MD.	
24. FUNERAL DIRECTOR NAME WILSON FUNERAL HOME		ADDRESS SALISBURY, MD.		25a. DATE REC'D. BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia M. Brady</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JUN 1, 1980

JUN 25, 1980

JUL 1, 1980

JUL 15, 1980

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 0 2 6 8 1					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Grason Embert										January 8, 1980				12:45 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.					
Male		White		January 29, 1901		78 YRS.									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.									
Maryland		USA													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital								Unemployed		---			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland Queen Anne's Queenstown												Del Rhodes Ave.			
14 FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Thomas Arthur Embert										Lillie Cecelia Booker					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b SOCIAL SECURITY NO.		17 INFORMANT			
No										213-50-5096-T		Brother, R.D.#9, Box 123, Lot 15 Charles G. Embert, Deton, Md. 21629			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordis Pulchey Fark 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cordis Pulchey Embert (c) Cordis Pulchey Embert										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None None None					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema															
MEDICAL CERTIFICATION															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				19											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 1/7 1980 to 1/8 1980, that (I) (we) last saw the deceased alive on 1/5 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE J.S. Green										DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/8/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J.S. Green										22e ADDRESS Bunney St. Salisbury, Md 21801					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE Jan. 10, 1980		23c NAME OF CEMETERY OR CREMATORY Chesterfield				23d LOCATION CITY OR TOWN COUNTY STATE Centerville, Q.A.Co., Md.					
24 FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617										25a DATE REC'D. BY REGISTRAR JAN 14 1980		25b REGISTRAR'S SIGNATURE R. H. Barton			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 3002682		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FLORENCE P. FLEISHHAUER				01-01-80		12:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		DEC. 4, 1894		85		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.		U.S.A.				Wicomico MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Wicomico Nursing Home		NONE					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
MD.		SOMERSET		PRINCESS ANNE <input type="checkbox"/> NO <input type="checkbox"/>		R.F.D. 1			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
WILLIAM H. POWELL		ANNIE HUDSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		214-10-7284A		MRS THELMA HICKMAN		PRINCESS ANNE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4073 } DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Heart Failure } (c) Atrial Fibrillation								MD. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost the deceased alive on 12/13/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
[Signature]		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/1/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
CREMATION		1/1/80		DELMARVA CREMATORY		LEWIS, DEL.			
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME		ADDRESS		JAN 1 1980					
WILSON FUNERAL HOME		SALISBURY, MD.							

BP



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 0 0 2 6 8 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BURTON			2a. DATE OF DEATH MONTH DAY YEAR January 16, 1980			2b. HOUR 12³⁰ A.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	
12b. KIND OF BUSINESS OR INDUSTRY Plumbing/Heating							
13a. STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John R. Foster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Phillips				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-05-2516		17. INFORMANT ADDRESS Helen F. Foster, Wife, Same as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car accident 496- DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1'
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 79 , to 1-16 , 19 80 , that (I) (we) last saw the deceased alive on 1-14 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William R. Ellis Jr. MD				DEGREE MD		22c. DATE SIGNED 1-16-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM R. ELLIS JR				22e. ADDRESS 1401 WISCONSIN AVE, SALISBURY MD 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/80		23c. NAME OF CEMETERY OR CREMATORY Grove Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Shelbyville Kentucky	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.,				ADDRESS 5130 Wisconsin Ave, Washington, D.C. 20016			

JAN 21 1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

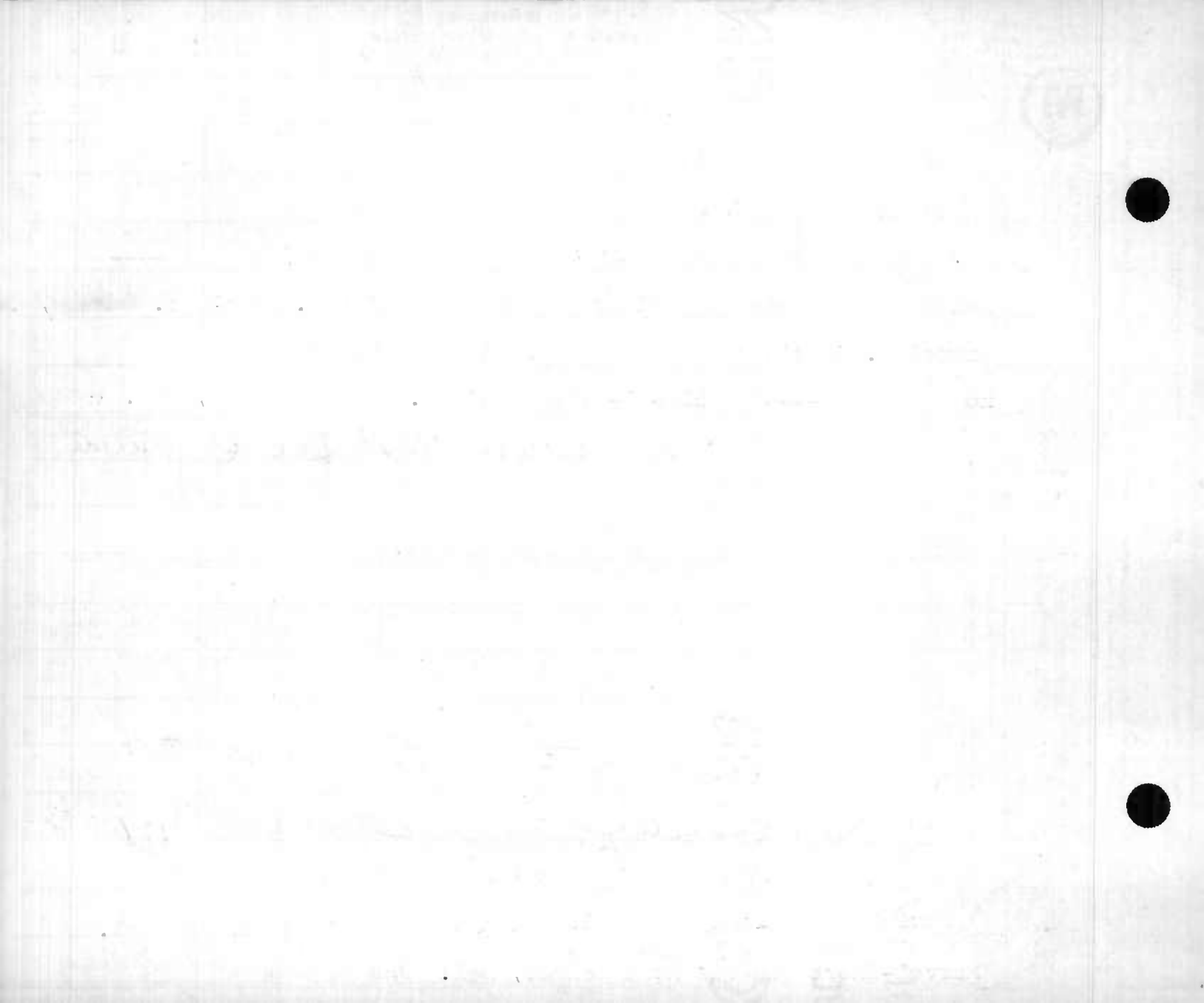
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 6 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Marion		A. FRANCIS		1-15-80		8:10 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	White	10-11-81		98 YRS.	3 4		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.			Wicomico MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury, Md.	Salisbury Nursing Home			Housewife		-----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Delaware		Sussex		Delmar	13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Samuel B. Hastings		Julia Anna Carmine		no ----- 222-07-8371			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		17a. NAME			
222-07-8371		Julia E. Smith		Delmar, Del. 19940			
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac infarct heart disease</u>							<u>within</u>
4140							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-15-80</u> 19 <u>80</u> , to <u>1-15-80</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>1-15-80</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William R. Ellis</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1-15-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
WILBER R. ELLIS, M.D.		SALISBURY, MD. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1-18-1980		Smith Mills		Delmar Sussex Del.	
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Marvel-Short Funeral Home		JAN 21 1980		Dorothy McBrady			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 24 HOURS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 72 HOURS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 90 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 180 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 5760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 11520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 23040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 46080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 92160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 184320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 368640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 737280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1474560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2949120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 5898240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 11796480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 23592960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 47185920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 94371840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 188743680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 377487360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 754974720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1509949440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3019898880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6039797760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 12079595520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 24159191040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 48318382080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 96636764160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 193273528320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 386547056640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 773094113280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1546188226560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3092376453120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6184752906240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 12369505812480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 24739011624960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 49478023249920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 98956046499840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 197912092999680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 395824185999360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 791648371998720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1583296743997440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3166593487994880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6333186975989760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 12666373951979520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 25332747903959040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 50665495807918080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 101330991615836160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 202661983231672320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 405323966463344640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 810647932926689280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1621295865853378560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3242591731706757120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6485183463413514240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 12970366926827028480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 25940733853654056960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 51881467707308113920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 103762935414616227840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 207525870829232455680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 415051741658464911360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 830103483316929822720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1660206966633859645440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3320413933267719290880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6640827866535438581760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 13281655733070877163520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 26563311466141754327040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 53126622932283508654080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 106253245864567017308160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 212506491729134034616320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 425012983458268069232640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 850025966916536138465280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1700051933833072276930560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3400103867666144553861120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6800207735332289107722240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 13600415470664578215444480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 27200830941329156430888960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 54401661882658312861777920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 108803323765316625723555840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 217606647530633251447111680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 435213295061266502894223360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 870426590122533005788446720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1740853180245066011576893440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3481706360490132023153786880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 6963412720980264046307573760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 13926825441960528092615147520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 27853650883921056185230295040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 55707301767842112370460590080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 111414603535684224740921180160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 222829207071368449481842360320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 445658414142736898963684720640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 891316828285473797927369441280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1782633656570947595854738822560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3565267313141895191709477645120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 7130534626283790383418955290240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 14261069252567580766837910580480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 28522138505135161533675821160960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 57044277010270323067351642321920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 114088554020540646134703284643840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 228177108041081292269406569287680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 456354216082162584538813138575360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 912708432164325169077626277150720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1825416864328650338155252554301440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3650833728657300676310505108602880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 7301667457314601352621010217205760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 14603334914629202705242020434411520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 29206669829258405410484040868823040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 58413339658516810820968081737646080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 116826679317033621641936163475292160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 233653358634067243283872326950584320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 467306717268134486567744653901168640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 934613434536268973135489307802337280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1869226869072537946270978615604674560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3738453738145075892541957231209349120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 7476907476290151785083914462418698240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 14953814952580303570167828924837396480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 29907629905160607140335657849674792960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 59815259810321214280671315699349585920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 119630519620642428561342631398691171840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 239261039241284857122685262797382343680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 478522078482569714245370525594764687360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 957044156965139428490741051189529374720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1914088313930278856981482102379058749440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3828176627860557713962964204758117498880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 7656353255721115427925928409516234997760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 15312706511442230855851856819032469995520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 30625413022884461711703713638064939991040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 61250826045768923423407427276129879982080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 122501652091537846846814854552259759964160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 245003304183075693693629709104519519928320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 490006608366151387387259418209039039856640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 980013216732302774774518836418078079713280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1960026433464605549549037672836156159426560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 3920052866929211099098075345672312318853120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 7840105733858422198196150691344624637706240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 15680211467716844396392301382689249275412480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 31360422935433688792784602765378498550824960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 62720845870867377585569205530756997101649920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 125441691741734755171138411061513994203299840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 250883383483469510342276822123027988406599680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 501766766966939020684553644246055976813199360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1003533533933878041369107288492111953626398720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2007067067867756082738214576984223907252797440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 4014134135735512165476429153968447814505594880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 8028268271471024330952858307936895629011189760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 16056536542942048661905716615873791258022379520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 32113073085884097323811433231747582516044759040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 64226146171768194647622866463495165032089518080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 128452292343536389295245732926990330064179136160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 256904584687072778590491465853980660128358272320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 513809169374145557180982931707961320256716544640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1027618338748291114361965863415922640513433089280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2055236677496582228723931726831845281026866178560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 4110473354993164457447863453663690562053732357120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 8220946709986328914895726907327381124107464714240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 16441893419972657829791453814654762248214929428480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 32883786839945315659582907629309524496429858856960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 65767573679890631319165815258619048992859717713920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 131535147359781262638331630517238097985719435427840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 263070294719562525276663261034476195971438870855680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 526140589439125050553326522068952391942877741711360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1052281178878250101106653044137904783885755483422720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2104562357756500202213306088275809567771510966845440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 4209124715513000404426612176551619135543021933690880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 8418249431026000808853224353103238271086043867381760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 16836498862052001617706448706206476542172087734763520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 33672997724104003235412897412412953084344175469527040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 67345995448208006470825794824825906168688350939054080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 134691990896416012941651589649651812337376701878108160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. 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IF THE DELAY IS MORE THAN 17240574834741249656531403475155431951984217840397844480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 34481149669482499313062806950310863903968435680795688960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 68962299338964998626125613900621727807936871361591377920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 137924598677929997252251227801243455615873742723182755840 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 275849197355859994504502455602486911223747485446365511680 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 551698394711719989009004911204938182447494970892731023360 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1103396789423439978018009822409876364894989941785462046720 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2206793578846879956036019644819752729789979883570924093440 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 4413587157693759912072039289639505459579959767141848186880 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 8827174315387519824144078579279010919159919534283696373760 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 17654348630775039648288157558558021838319839068567392747520 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 35308697261550079296576315117116043676639678137134785495040 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 70617394523100158593152630234232087353279356274269570990080 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 141234789046200317186305260468464147064558712548539141980160 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 282469578092400634372610520936928294129117425097078283960320 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 564939156184801268745221041873856588258234850194156567920640 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 1129878312369602537490442083747713176516469700388313135841280 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 2259756624739205074980884167495426353032939400776626271682560 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 4519513249478410149961768334990852706065878801553252543365120 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 9039026498956820299923536669981705412131757603106505086730240 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 18078052997913640599847073339963410824263515206213010173460480 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 36156105995827281199694146679926821648527030412426020346920960 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 72312211991654562399388293359853643297054060824852040693841920 DAYS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE OR IN PERSON. IF THE DELAY IS MORE THAN 144624439923309124



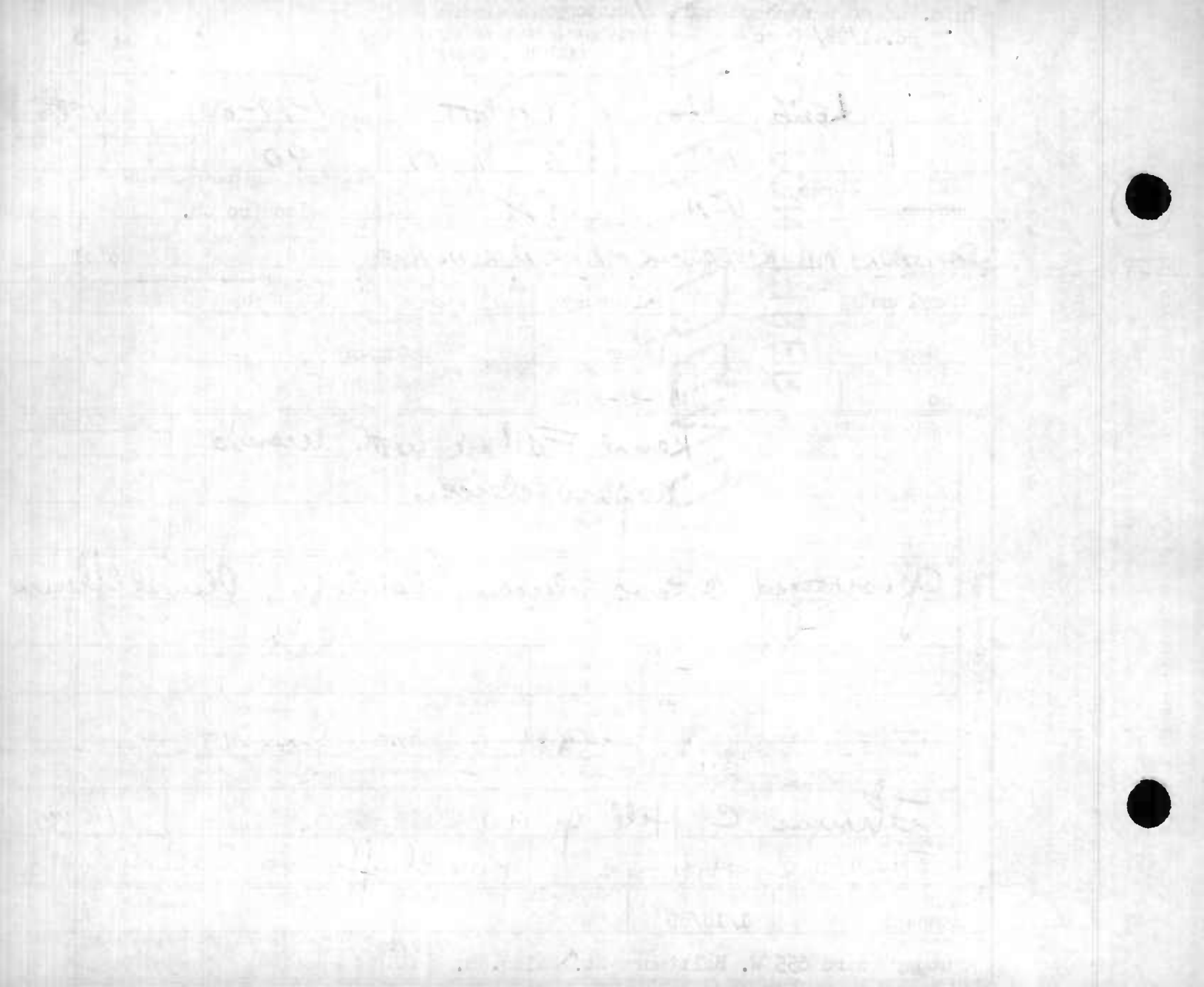
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Info. added per phone call w/Anatomist										STATE OF MARYLAND																			
1. FOR Bd. 1/28/80 re										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
1. STATE REGISTRAR										CERTIFICATE OF DEATH																			
REG. NO.																													
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH					MONTH DAY YEAR					2b. HOUR									
LENA					L					GAUATT					1-17-80					10 ³⁰ PM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					7. IF UNDER 1 YEAR									
F					W					6 9 89					90 YRS					MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH														
New Jersey					USA										Wicomico Co. MD.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY														
SALISBURY, MD					RIVERWALK MANOR NURSING HOME					Maid					Hotel														
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS									
Maryland					Wic.					Salisbury					YES <input type="checkbox"/> NO <input type="checkbox"/>					unknown									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
George					Baker					Unknown																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS																			
No					141-22-9071																								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
IMMEDIATE CAUSE (a) Renal Failure with uremia																													
4039 DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																													
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																													
Generalized Arteriosclerosis, Senility, Pleural Effusion																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																			
					HOUR A.M. MONTH DAY YEAR																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY					21f. LOCATION																			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that this hospital attended the deceased from Oct 6, 1975, to Jan 17, 1980, that (we) lost saw the deceased alive on Jan 17, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)																													
22b. SIGNATURE															DEGREE					22c. DATE SIGNED									
Thomas C Hill Jr															M.D.					1/18/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)															22e. ADDRESS														
THOMAS C. Hill Jr															Pine Bluff Road, Salisbury Md														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION														
Removal					1/18/80										CITY OR TOWN COUNTY STATE														
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
NAME ADDRESS										JAN 31 1980										Anthony McCreedy									
Anatomy Board 655 W. Baltimore St. Balto. Md.																													

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0002687							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernard R. Gillette						2a. DATE OF DEATH MONTH DAY YEAR January 7 1980		2b. HOURS 2230 M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION River Walk Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Mechanic	
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. STREET ADDRESS 420 Linden Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Hillary Gillette		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Hall		16. ADDRESS 28 Woodrow St. Chester, Pa.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-01-8627		17. INFORMANT Bernard C. Gillette					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis - DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from Dec 13, 1978, to Jan 7, 1980, that (we) lost saw the deceased alive on Jan 7, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.									
22b. SIGNATURE Thomas C. Hill Jr. M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/7/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HILL JR.		22e. ADDRESS Pine Bluff Road, Salisbury Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-12-80		23c. NAME OF CEMETERY OR CREMATORY Tindley Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Wor Md.			
24. FUNERAL DIRECTOR NAME Samuel G. Savage		ADDRESS New Church, Va.		25a. DATE REC'D. BY REGISTRAR JAN 14 1980		25b. REGISTRAR'S SIGNATURE Pitney Kennedy			

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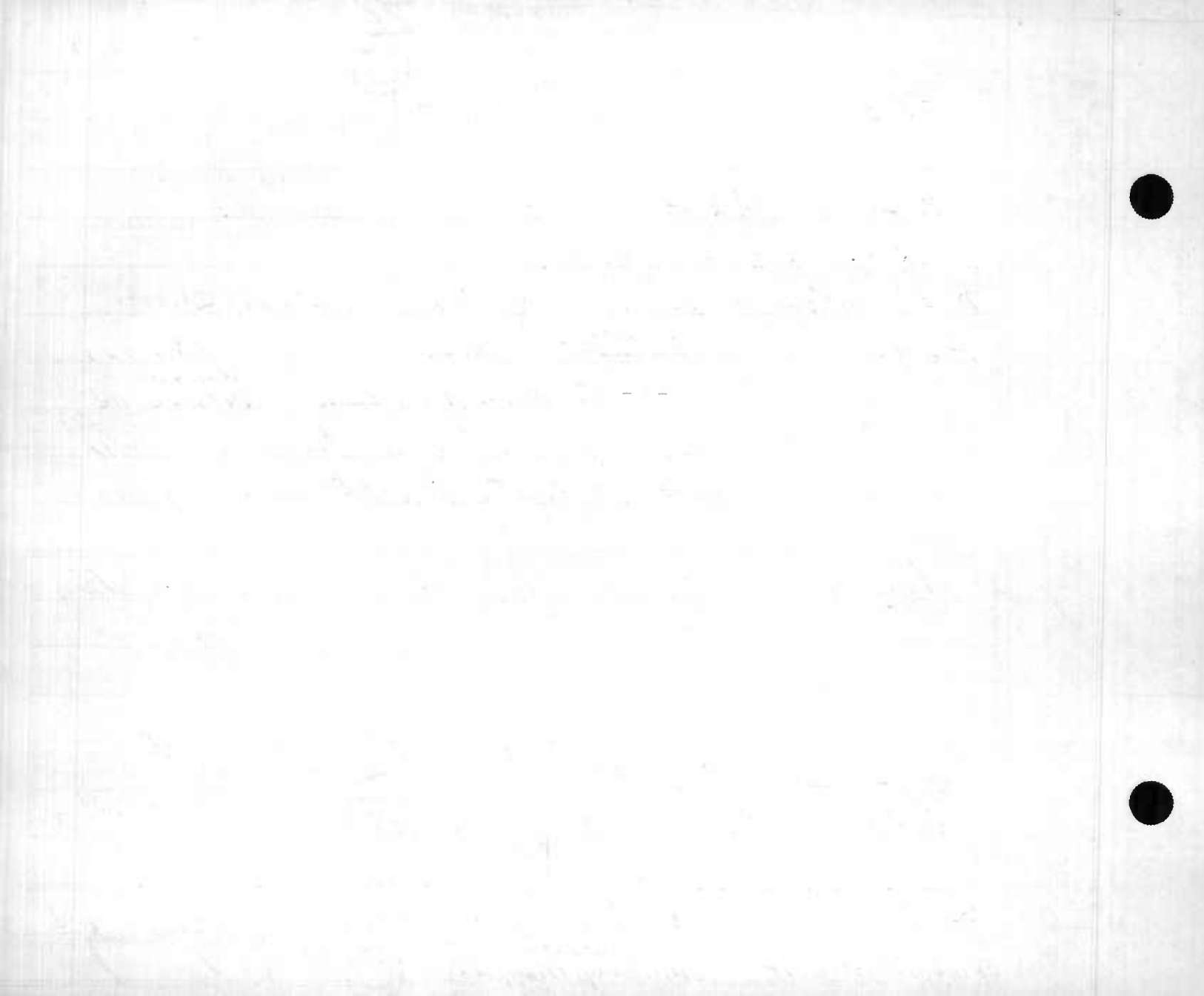
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 0 2 6 8 8			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ELIZABETH G. TREATH</i>				2b. HOUR <i>10:15 AM</i>			
3. SEX <i>F</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11-16-89</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>90</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Salisbury, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Salisbury Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i></i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Delmar</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Abner Chapman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY Chapman</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>201-03-6093</i>	
17. INFORMANT <i>Mrs. William Banks</i>		ADDRESS <i>Robtill Delmar, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>		410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes mellitus, atrial fibrillation, previous infarction.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19 71</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. SIGNATURE <i>Earl M. Beardsley</i> MD		22b. DATE SIGNED <i>11/7/79</i>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EARL M. BEARDSLEY, M.D.</i>		22d. ADDRESS <i>Ciciv Ave. & Rt. 50, Salisbury, Md.</i>		23a. NAME OF CEMETERY OR CREMATORY <i>Green Glean Memorial</i>		23b. LOCATION CITY OR TOWN COUNTY STATE <i>Salisbury, Wicomico Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Clinton F. Stewart</i>		ADDRESS <i>West Rd + Olivia St Salisbury, Maryland</i>		25. DATE REC'D. BY REGISTRAR <i>JAN 24 1980</i>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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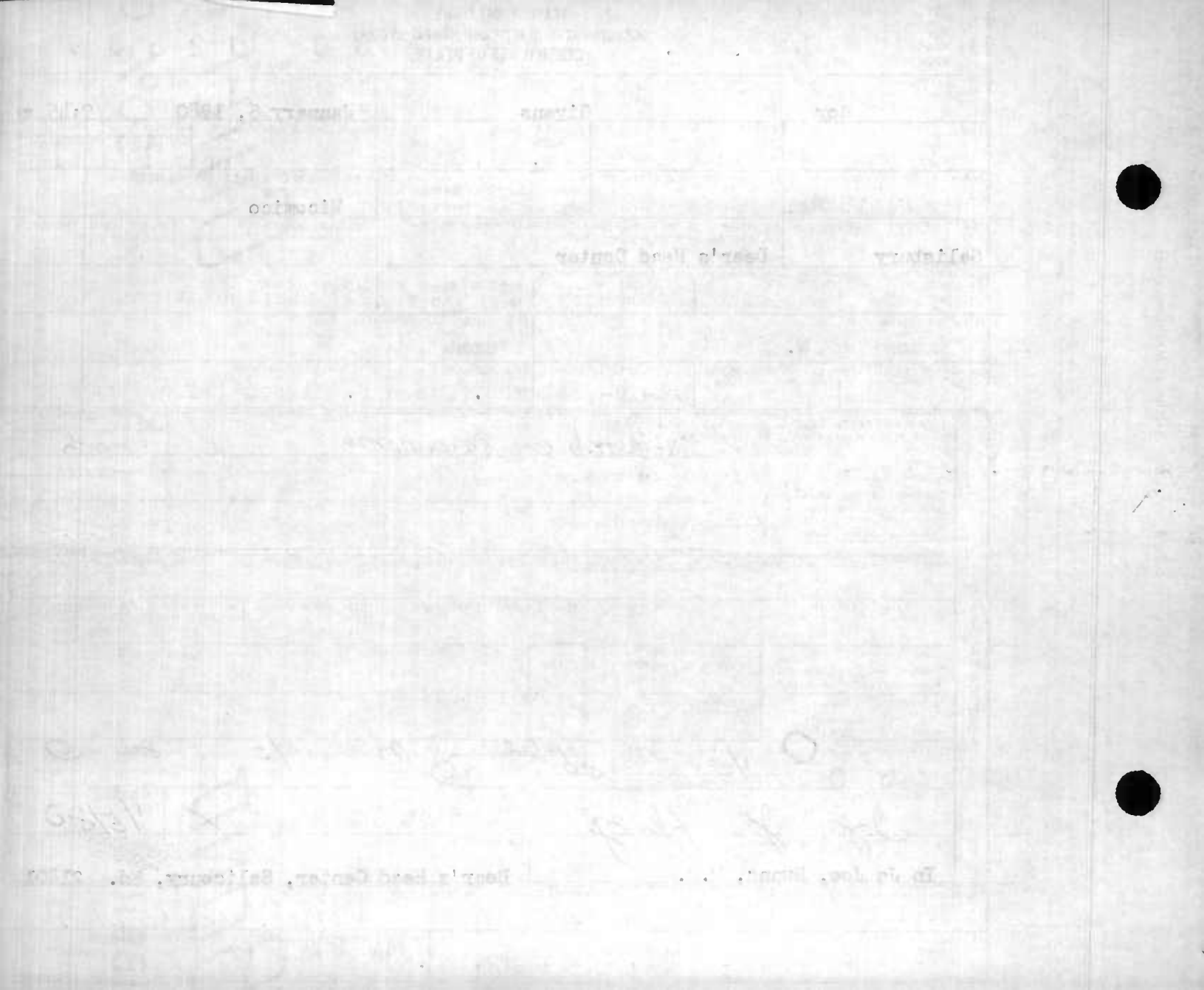
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH0002689
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Roy Hudson Givans		January 5, 1980		9:45 am	
3 SEX	4 RACE	5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male	White	Oct. 31, 1908		71		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Snow Hill, Md.	USA			Wicomico MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury	Deer's Head Center		Route Salesman		Beverage		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Wicomico	Salisbury	YES <input type="checkbox"/> NO <input type="checkbox"/>		317 Charles Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Ernest W. Givans		Emma Hudson		16b. SOCIAL SECURITY NO.			
				214-10-6391			
				17. INFORMANT ADDRESS			
				Mrs. Clara P. Givans (wife) same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>79</u> , to <u>1/5</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>In Ja Joe, Hwang, M.D.</u>		<u>MD</u>				<u>1/5/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/8/80		Allen Cemetery		Allen, Wicomico, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY FUNERAL HOME, Salisbury, Md.				JAN 9 1980		<u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) LEON SEYMOUR GIVARZ						2a. DATE KNOWN OF DEATH ESTIMATED 1-3-80			2b. HOUR A.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 9 17	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 1-3-80 19 9:45A			2d. HOUR A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pocomoke City, Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10. CITY OR TOWN OF DEATH Pittsville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Morris Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) disabled			12b. KIND OF BUSINESS OR INDUSTRY none		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Pittsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Morris Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Givarz						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Heilig					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-10-8716A		17. INFORMANT ADDRESS 324 Glen Ave. Mr. Alex M. Kravitz, Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 1-3-80			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/80		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR JAN 8 1980		25b. REGISTRAR'S SIGNATURE <i>Earl L. Royer</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) RUSSELL WINSTON Gravenor					2a. DATE OF DEATH MONTH DAY YEAR January 30, 1980			2b. HOUR 6³³/P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9/19/1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. # UNDER 1 YEAR # UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mailman		12b. KIND OF BUSINESS OR INDUSTRY Postal Service		
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Parsonsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Walston Switch Road	
14. FATHER'S NAME FIRST MIDDLE LAST William Gravenor					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Parsons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-01-8845		17. INFORMANT ADDRESS Mrs. Ada M. Gravenor (wife) Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/12/1966 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/12/1966 to 1/30/1980					
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did not) see the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE [Signature] DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/4/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oswald J. Burton, M.D.					22e. ADDRESS 307 Kay Ave., Salisbury, MD 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/2/80		23c. NAME OF CEMETERY OR CREMATORY Allen Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Allen, Wicomico, Maryland			
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. ADDRESS					25a. DATE REC'D. BY REGISTRAR FEB 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

January 30, 1980

Gravener

Victoria

Peninsula General Hospital

Calgary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002692			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Levin Elwood GRAY				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3 1980				2b. HOUR 6:25 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb 28 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mail & school		12b. KIND OF BUSINESS OR INDUSTRY bus cont.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Elliott		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rural					
14. FATHER'S NAME FIRST MIDDLE LAST L. Austin Gray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Hurley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT ADDRESS Mrs. XXXXX Norma Lee Gray Elliott Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia (c) HISTIOCYTIC LYMPHOMA CENTRAL NERVOUS SYSTEM										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min 2 wks. 4 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 6 , 19 79 , to Jan 3 , 19 80 , that (I) (we) last saw the deceased alive on Jan. 3 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Allen W. Tustin				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/3/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. TUSTIN				22e. ADDRESS 209 MARYLAND AVE., SALISBURY, MD 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1/6/80		23c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.							
24. FUNERAL DIRECTOR NAME Thomas Funeral Home				ADDRESS Cambridge Md. 21613				25a. DATE REC'D. BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE Robert M. Cuddy			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02693	
1. DECEASED NAME (TYPE OR PRINT) Eugene Paul Greenfield										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1-12-80	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2-20-20		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-12-80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D. C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula Gen'l Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE D. C.				13b. COUNTY Wash. D.C.		13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1321 44th St. N.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Greenfield						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roy Marie Pinkiard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 578-07-1412		17. INFORMANT ADDRESS Mrs. Portia Greenfield/wife/same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Hypertensive C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c)										Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 1-13-80			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave. Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-17-80		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Leah H. Boardley Cambridge, Md.						25a. DATE DIED BY REGISTRAR JAN 21 1980		25b. REGISTRAR'S SIGNATURE <i>Robert McCready</i>			

6:37
6:37
6:37

1967-2-25

Administrative

1967-2-25

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1967-2-25

Administrative

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

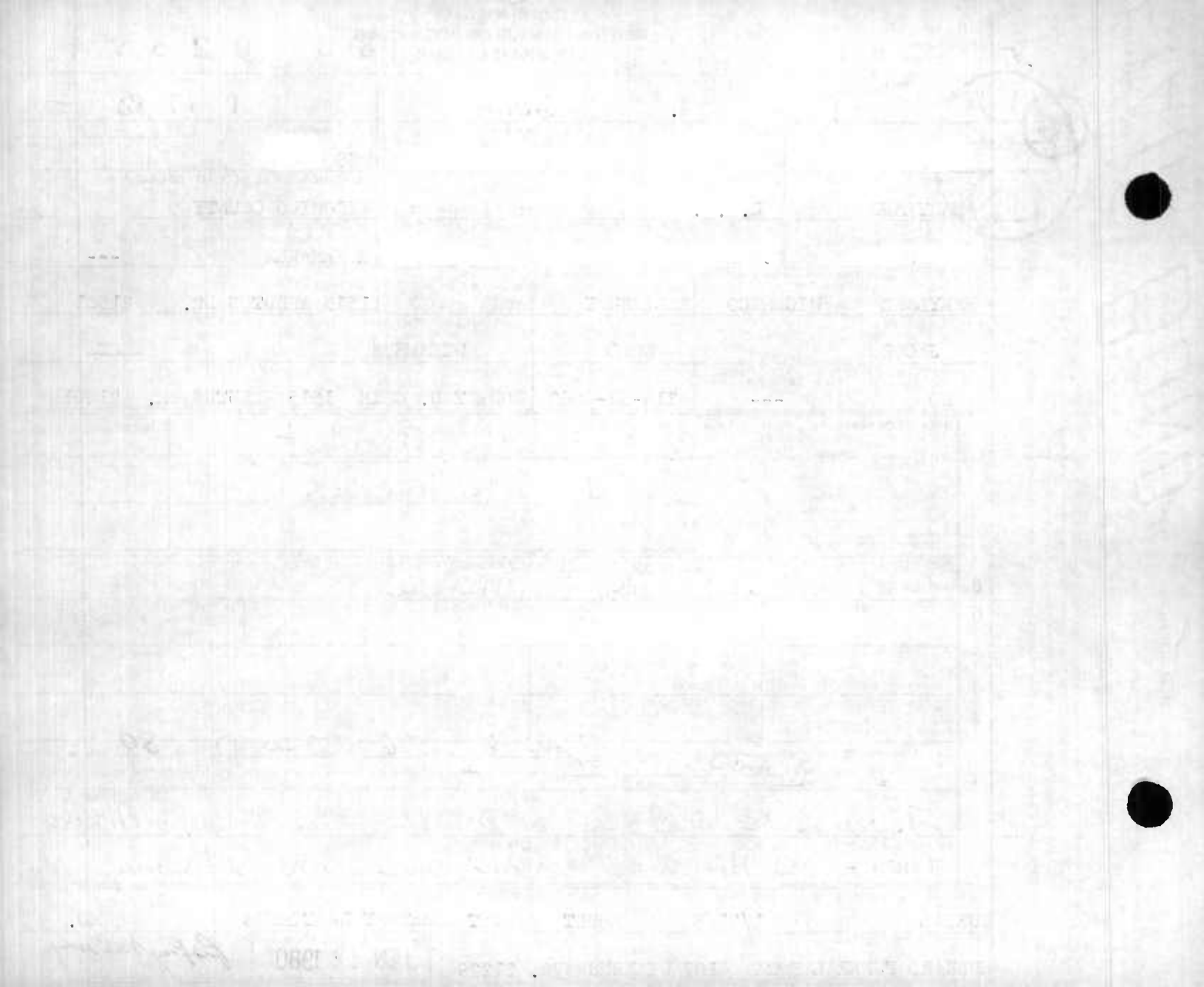
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 3 must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8002694				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORA E. GRIM					2a. DATE OF DEATH MONTH DAY YEAR 1 17 80			2b. HOUR 7 ³⁰ PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 14 91		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD.			
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERWALK MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1515 ARBUTUS DR. 21801	
14 FATHER'S NAME FIRST MIDDLE LAST JACOB			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILAMENA PLETZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17 INFORMANT ROBERT B. GRIM		ADDRESS 1515 ARBUTUS DR. 21801			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 436 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from Jan 16, 19 76, to Jan 17, 19 80, that (we) last saw the deceased alive on Jan 17, 19 80, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas C Hill Jr				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. Hill Jr				22e. ADDRESS Pine Bluff Road, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/21/80		23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24 FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR JAN 22 1980		25b. REGISTRAR'S SIGNATURE Dorothy K. Brady			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		71. CITIZEN OF WHAT COUNTRY?		72. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		73. KIND OF BUSINESS OR INDUSTRY	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR		3. SEX		4. RACE	
ROSE		January 12 1980		12 12 AM		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Feb. 4, 1897		82 YRS		Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. STREET ADDRESS		14. FATHER'S NAME	
Salisbury		Peninsula General Hospital		Retired Owner		Clothing Store		Abraham	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. SOCIAL SECURITY NO.		17. INFORMANT (son)		18. ADDRESS		19. MOTHER'S MAIDEN NAME	
Maryland		216-38-9336		Mr. Alan B. Groh, Flossmoor, Ill.		2939 Scott-Crescent		Molly	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Worcester		Pocomoke City		YES <input type="checkbox"/> NO <input type="checkbox"/>		505 Market Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. SOCIAL SECURITY NO.		18. INFORMANT (son)	
Abraham		Molly		No		216-38-9336		Mr. Alan B. Groh, Flossmoor, Ill.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY?	
PART I. DEATH WAS CAUSED BY								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IMMEDIATE CAUSE (a)								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4392								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
CHRONIC HEART FAILURE								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY	
		HOUR A.M. MONTH DAY YEAR				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]	
		P.M. 19				CITY OR TOWN		COUNTY	
						STATE			
22a. I certify that (I) (the hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
12-17, 1978, to 1-12-1980, that (I) (we) last saw the deceased alive on 1-11-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		James L. Clifford M.D.		1-15-80		JAMES L. CLIFFORD M.D.		#12 MEDICAL CENTER Salisbury, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial		1/13/80		Beth Israel Cemetery		Salisbury, Wicomico, Maryland		STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
NAME		ADDRESS							
HOLLOWAY FUNERAL HOME, Salisbury, Md.									

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1-15-88

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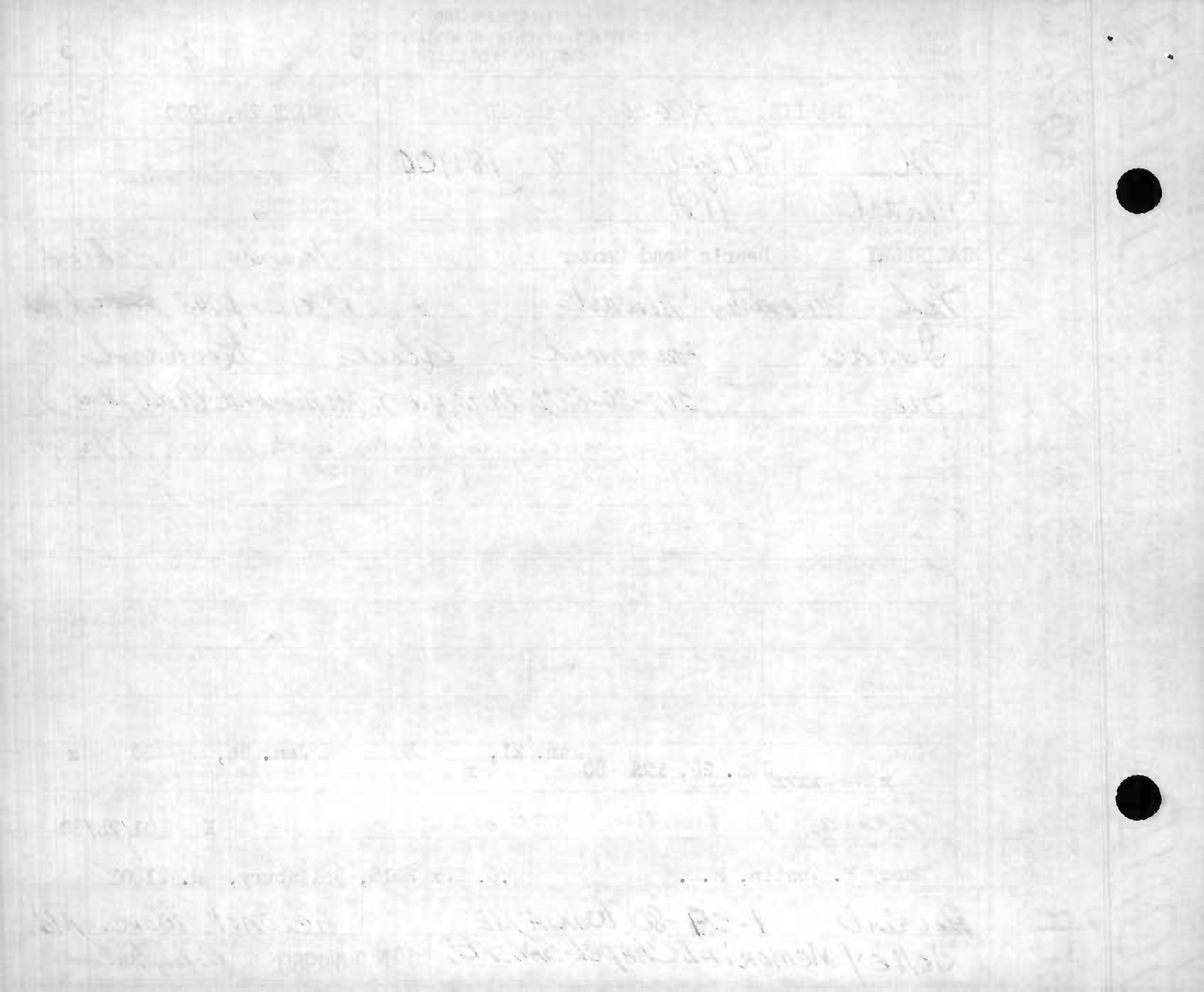
1-11-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, and a 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002696					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLIE Reese HAMMOND										JANUARY 24, 1980				7:15am	
3. SEX M		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 8 18 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Newark		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO, MD.									
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Retired							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Md. Worcester Newark						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt #1 Box 148 Newark, Md.							
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Hammond				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Richard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 217-30-8230		17. INFORMANT ADDRESS Maggie T. Hammond (Add. same)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1539 Adenocarcinoma of colon with local recurrence & lung metastases DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Jan. 21, 1980, to Jan. 24, 1980, that I (we) last saw the deceased alive on Jan. 24, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.															
22b. SIGNATURE DEGREE Nancy W. Tustin, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01/24/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.						22e. ADDRESS P.O. Box 2018, Salisbury, Md. 21801									
23a. BURIAL, CREMATION REMOVAL (SPECIFY) Burial		23b. DATE 1-28-80		23c. NAME OF CEMETERY OR CREMATORY Wm's A ME		23d. LOCATION CITY OR TOWN COUNTY STATE Newark Wore. Md.									
24. FUNERAL DIRECTOR NAME Solley Memorial Chapel-Salisbury						25a. DATE REC'D. BY REGISTRAR JAN 30 1980		25b. REGISTRAR'S SIGNATURE Pitney Helmsley							



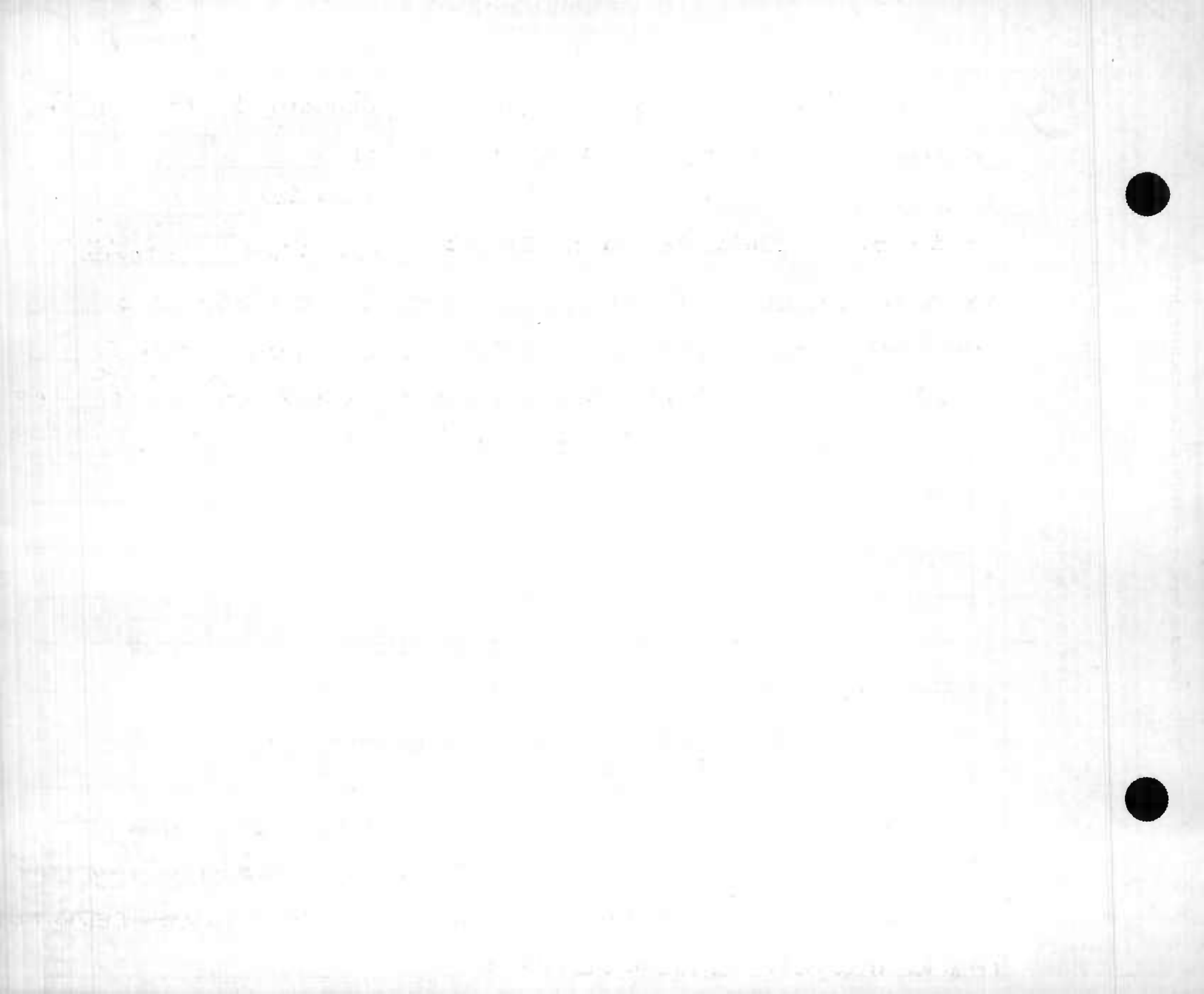
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8002697							
1. DECEASED NAME (TYPE OR PRINT) LINWOOD McLox Hearn					2a. DATE OF DEATH MONTH DAY YEAR January 5, 1980			2b. HOUR 10 ¹⁸ P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR AUG. 19, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) meat cutter		12b. KIND OF BUSINESS OR INDUSTRY chain stores	
13a. STATE DELAWARE		13b. COUNTY SUSSEX		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD #3 BOX 58C - ALT. 13	
14. FATHER'S NAME FIRST MIDDLE LAST HAROLD F. HEARN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE MITCHELL HEARN HONTZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. - (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS RD 3 BOX 58C WILLIE O'DAY HEARN - LAUREL, DELAWARE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer lung 1609 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Liver Cirrhosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1975 to 1/5 1980, that (I) (we) last saw the deceased alive on 1/5 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Z. Badros, M.D. ATTENDING PHYSICIAN						22c. DATE SIGNED 1/6/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Z. Badros				22e. ADDRESS 229 Florida Ave Salisbury Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 9, 1980		23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SEAFORD SUSSEX DELAWARE			
24. FUNERAL DIRECTOR NAME Paynter M. Watson - SEAFORD, DELAWARE				25a. DATE REC'D. BY REGISTRAR JAN 11 1980		25b. REGISTRAR'S SIGNATURE			

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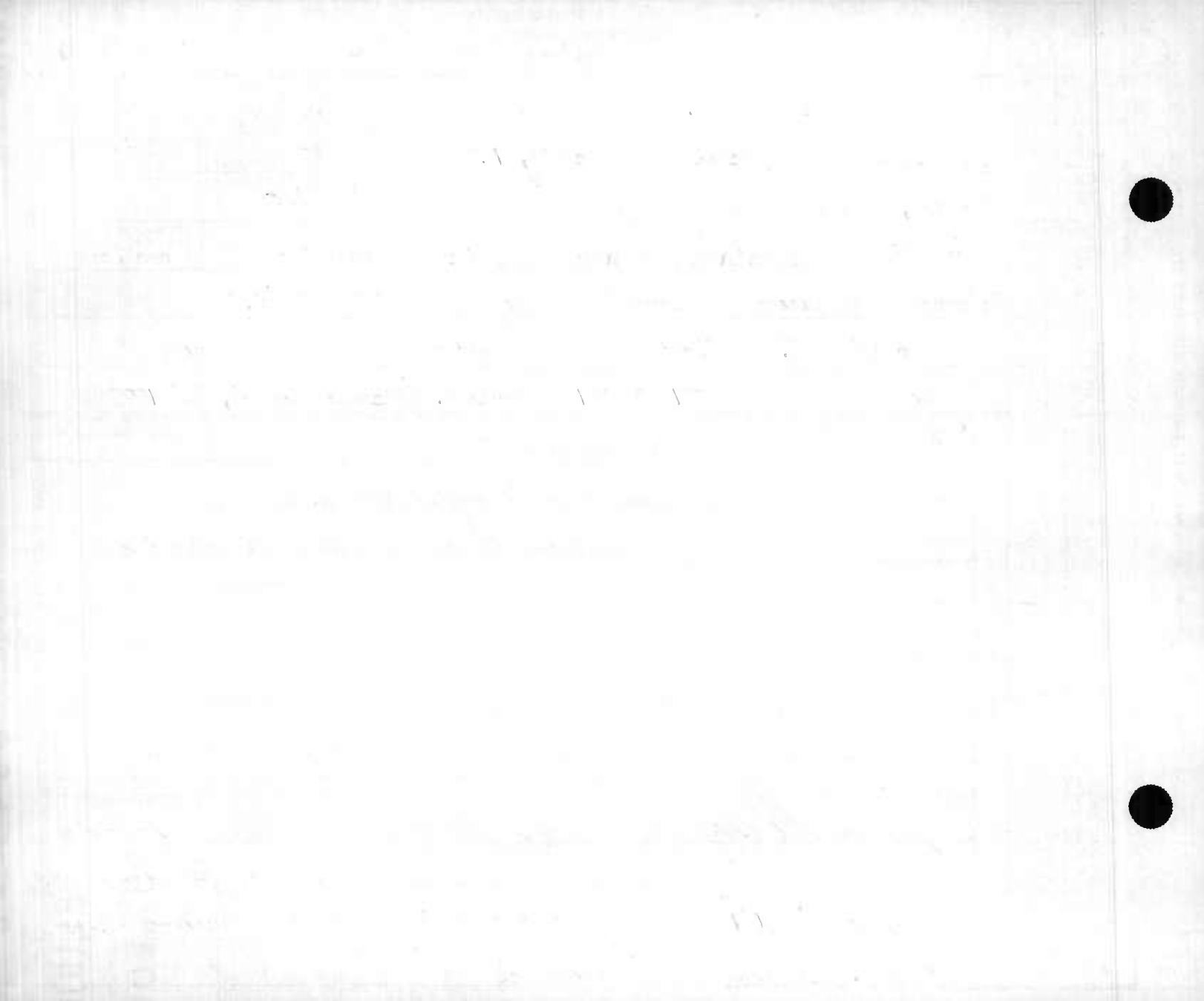
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002698					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Blanche		D.		HITCHENS				JANUARY 11, 1980					3:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		Caucasian		Oct 29, 1894		85 YRS		MONTHS		DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Seaford, Delaware		USA				Wicomico									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury		Peninsula General Hospital		housewife		own home									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Delaware		Sussex		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		207 7th St.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST		FIRST MIDDLE LAST													
Joseph L. Short		Bertha Pusey													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
no		221 09 4301		Louis V. Hitchens		Laurel, Del 19956									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1- Cardiac arrest 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2- Probable acute myocardial infarction (c) 3- Arteriosclerotic (cardiovascular) disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1-10-1980 to 1-11-1980, that (I) (we) lost saw the deceased alive on 1-11-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE James L. Clifford M.D.		DEGREE M.D.		22c. DATE SIGNED 1-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
JAMES L. CLIFFORD M.D.										#12 Medical Center Salisbury, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
burial		1/15/80		Odd Fellows Cemetery		Laurel Sussex Delaware									
24. FUNERAL DIRECTOR NAME Homer L. Disharoon						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
box 678 Laurel Del						JAN 22 1980		Dorothy McCready							

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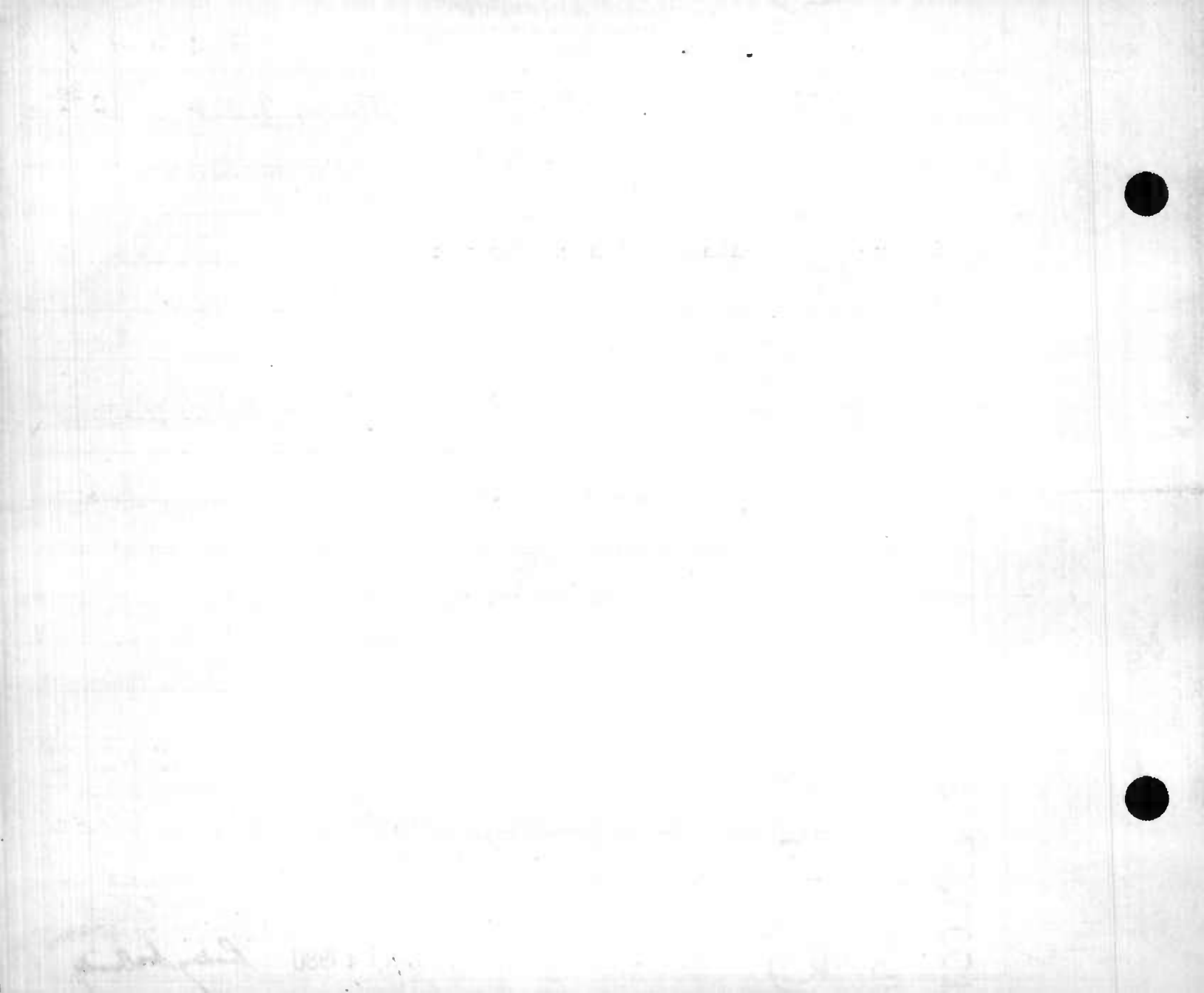


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 02699			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN Frances HOFF				2b. HOUR 2 30 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1929		6. AGE (IN YEARS (LAST BIRTHDAY)) 50 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Accomac, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Filmore Simpson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Gertrude Frazier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS same as 13 Mr. Robert G. Hoff (Husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic Shock 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Myocardial Infarction (c) Due to, or as a consequence of							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetic Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 1/8 19 80 to 1/9 19 80 , that (I) (we) last saw the deceased alive on 1/9 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benito S. Chan		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN		22e. ADDRESS 547-D Riverside Drive					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/80		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME				ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR JAN 14 1980	
				25b. REGISTRAR'S SIGNATURE Robert G. Hoff			



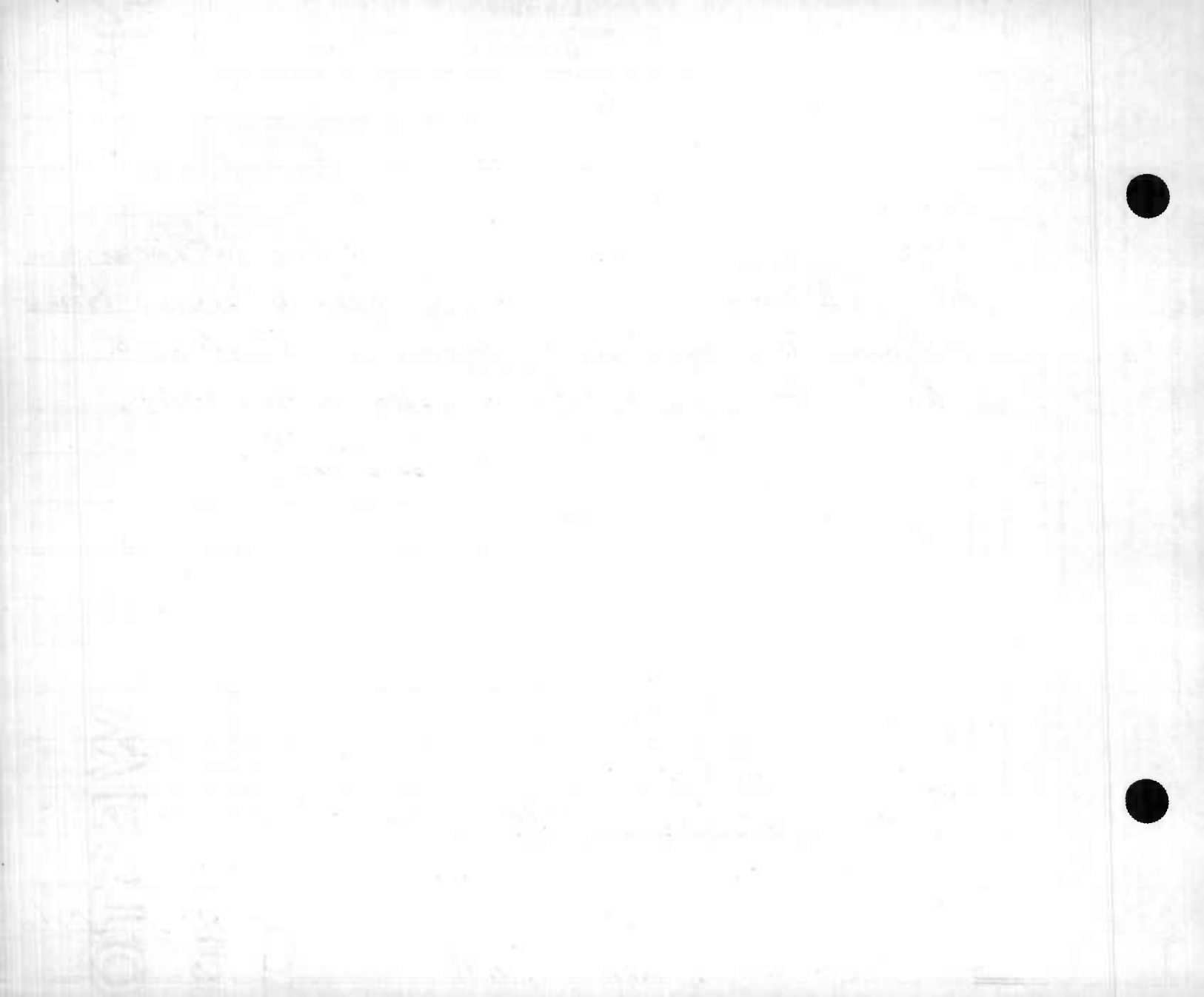
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002700			
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mattie D. Holland				2a DATE OF DEATH MONTH DAY YEAR 1-24-80				2b HOUR 6:45 AM			
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 8-19-94		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.							
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Matron		12b KIND OF BUSINESS OR INDUSTRY Parson's Home					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md.		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS John B. Parsons Home					
14 FATHER'S NAME FIRST MIDDLE LAST William D. Dashiell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bloodsworth											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-05-9684		17 INFORMANT ADDRESS John B. Parsons Home Records									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of colon with metastasis 1539 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 1/3 1980 to 1/24 1980, that (I) (we) lost sight of the deceased alive on 1/25 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) and (d) did not yet on the body after death.													
22b SIGNATURE Earl M. Beardsley				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 1/24/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. EARL M. BEARDSLEY				22e ADDRESS CIVIC AVE, & RT. 50, SALISBURY, MD.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 1/26/1980		23c NAME OF CEMETERY OR CREMATORY St Andrews Epis Cem		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.							
24 FUNERAL DIRECTOR NAME Hill-Baker-Bounds				ADDRESS Salisbury Md		25a DATE REC'D. BY REGISTRAR JAN 28 1980		25b REGISTRAR'S SIGNATURE [Signature]					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 8002701									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur R. HUDSON						2a. DATE OF DEATH MONTH DAY YEAR January 18, 1980		2b. HOUR 7:00 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2-1-06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME) RET. SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY DELAWARE SUSSEX						13c. CITY OR TOWN SELBYVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARMWELL HUDSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAVINA STEVENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 121-14-7987		17. INFORMANT ADDRESS FRANKLES P. HUDSON SELBYVILLE, DEL.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward P. Ritchings, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Ritchings, M.D.				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-20-80		23c. NAME OF CEMETERY OR CREMATORY RED MEN		23d. LOCATION CITY OR TOWN COUNTY STATE SELBYVILLE SUSSEX DEL.			
24. FUNERAL DIRECTOR NAME Peter Whaley ADDRESS Selbyville Del.				25a. DATE REC'D. BY REGISTRAR JAN 22 1980		25b. REGISTRAR'S SIGNATURE Patricia McCready			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3002702					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Reba Hudson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-24-80</i>				2b. HOUR <i>1:45 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 15 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>W</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Grant Brewington</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Green</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>057-14-1396</i>		17. INFORMANT <i>Ann Hudson</i>		ADDRESS <i>Tusculum Ave Salisbury, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca. of Pancreas</i> <i>1579</i> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>22 Jan 1980</i> , to <i>24 Jan 1980</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>24 Jan 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. A. Purnell, MD</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5 Feb 80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. A. Purnell, MD</i>				22e. ADDRESS <i>652 W. Main St. Salisbury, Md 21801</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-30-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Acre Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Salisbury Wicomico Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Clinton F. Steward Funeral Home</i>				ADDRESS <i>West 21st & Olive St Salisbury, Md</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 1 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Barbara B. Brady</i>	

BP

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(VR A 15 (4)) 9/74

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 80 02703							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Jarvis HURD				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1980		2b. HOUR 3:59 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 - 17 - 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Post Office	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Del.				13b. COUNTY Kent		13c. CITY OR TOWN Harrington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Hurd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Jarvis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW2 222 07 7252		17. INFORMANT ADDRESS 258 Delaware Ave. Doris A. Hurd, Harrington, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Refractory CHF</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary artery Disease</u> (c) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr 3 yr 10 yr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>77</u> , to <u>1/76</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>1/7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. L. Ruffetto				DEGREE MD				22c. DATE SIGNED 1/10/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. L. Ruffetto				22e. ADDRESS 21801 SALISBURY MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/10/80		23c. NAME OF CEMETERY OR CREMATORY Barratts Chapel		23d. LOCATION CITY OR TOWN Frederica		23e. COUNTY, STATE Kent, Del.	
24. FUNERAL DIRECTOR J. L. Ruffetto				ADDRESS Milford, Del.		25. DATE RECD. BY REGISTRAR JAN 11 1980		REGISTRAR'S SIGNATURE J. L. Ruffetto	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 0002704				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elijah D JOHNSON					2a. DATE OF DEATH MONTH DAY YEAR January 18, 1980			2b. HOUR 7:00 AM	
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 21 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Sea Food		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Som 13c. CITY OR TOWN Marion					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 110 Marion Md.		
14. FATHER'S NAME FIRST MIDDLE LAST Dennard Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Steward				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-12-3312		17. INFORMANT ADDRESS Lollie Johnson - Marion Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple myeloma 2030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. P. Ritchings, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/18/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Ritchings, M.D.					22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/80		23c. NAME OF CEMETERY OR CREMATORY MT. DEER		23d. LOCATION CITY OR TOWN Marion		23e. COUNTY STATE Md.	
24. FUNERAL DIRECTOR: NAME Anthony E. New Crispfield, Md.					25a. DATE REC'D. BY REGISTRAR JAN 25 1980		25b. REGISTRAR'S SIGNATURE Anthony E. New		

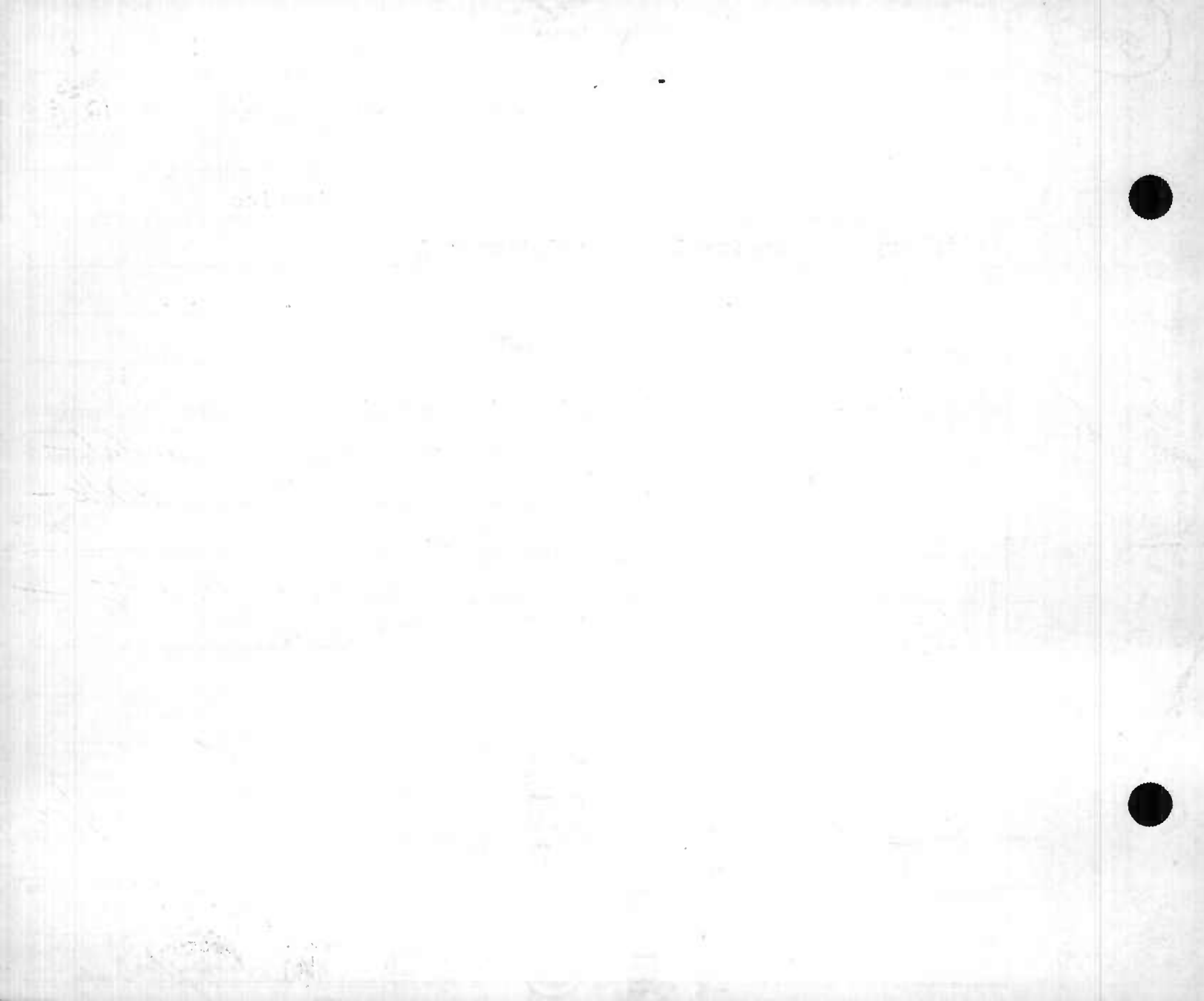


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002705	
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Merle Axel Jolander				2a DATE OF DEATH MONTH DAY YEAR January 29, 1980			2b HOUR 12 ²⁰ A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 11, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) officer		12b KIND OF BUSINESS OR INDUSTRY security guards	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b CITY OR TOWN Wicomico		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 109 Walston Ave.				
14 FATHER'S NAME FIRST MIDDLE LAST Axel Jolander			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Gordon								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. WW II 004-01-3678		17 INFORMANT ADDRESS same as 13 Mrs. Mabel I. Jolander (wife)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease -</i> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Established Atherosclerosis with</i> DUE TO, OR AS A CONSEQUENCE OF <i>Right Hemiplegia -</i> (c) <i>3 months -</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months -</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Extensive soft tissue loss and infection Right Leg -</i>											
18a DATE OF OPERATION 1/28/80			18b CONDITION FOR WHICH OPERATION WAS PERFORMED Extensive soft tissue loss			18c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>12/6/80</i> , 19____, to <i>1/28/80</i> , that (I) (we) lost saw the deceased alive on <i>1/28/80</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.											
22b SIGNATURE <i>[Signature]</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 1/29/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert Phleggy MD			22e ADDRESS Salisbury, Maryland								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 1/31/80		23c NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens			23d LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland			
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL			HOME, ADDRESS Salisbury, Md.			25a DATE REC'D. BY REGISTRAR FEB 1 1980		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 0 0 2 7 0 6 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Julian S. Jones Jr.			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1980			2b. HOUR 11:50 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 18 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Automotive		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Wor		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7-A 37th St.	
14. FATHER'S NAME FIRST MIDDLE LAST Julian S. Jones, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zayde E. Pope							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-10-4736		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>496-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Airway Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arteries + liver failure</u>										
19a. DATE OF OPERATION 1-9-80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pneumectomy of pneumonia</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/6/80</u> , 19 <u>80</u> , to <u>1/29</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Philip A Insley Jr.</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/29/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Philip A Insley Jr.</u>			22e. ADDRESS <u>Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 1/30/80		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.					25a. DATE REC'D. BY REGISTRAR FEB 04 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McCreary</u>			

100-100000

Peninsula General Hospital

San Francisco

FEB 4 1980

W. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

800 02707

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) STANLEY WALTER JONES			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7 1980			2b. HOUR 3:00 P.M.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 30, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Olive Hill, Ky.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical contractor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Somerset		13c. CITY OR TOWN Princess Anne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Allison Jones			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Clay			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) Yes WW II			
16b. SOCIAL SECURITY NO. WW II			17 INFORMANT Mrs. Betty Jo Jones (wife) same as			13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pulmonary Embolism</u> (c) <u>Coronary Artery Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>not</u> <u>yes</u> <u>yes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>78</u> to <u>1/7</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/7/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>			22e. ADDRESS Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/10/80		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Md.		
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR JAN 11 1980			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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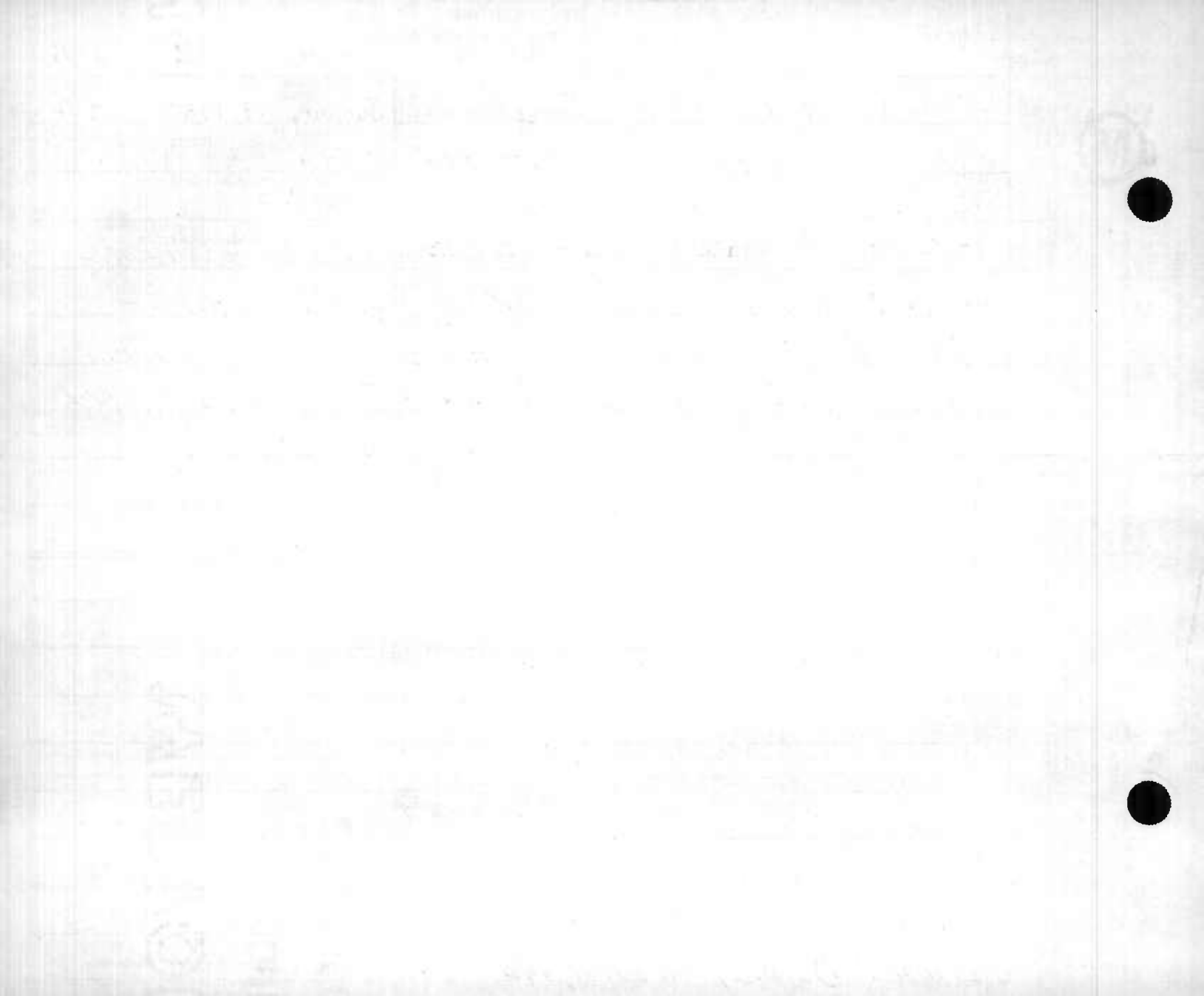
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 7 0 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William (Willie) A. Jones</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>January 19, 1980</i>				2b. HOUR <i>10¹⁹ P.M.</i>				
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3-1-1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.							
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Poultry</i>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Maryland Worcester Snow Hill</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>405 W. Market St.</i>						
14. FATHER'S NAME FIRST MIDDLE LAST <i>Donald Jones</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Corbin</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR AND DATES) <i>Yes WWI</i>					16b. SOCIAL SECURITY NO. <i>218209575</i>		17. INFORMANT ADDRESS <i>Raymond Jones, Snow Hill, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> <i>4409</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Unfixed Atherosclerosis</i> (c) <i>Large Tumor</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dehydration</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1/19</i> 19 <i>80</i> , to <i>1/19</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>1/19</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Helen M. Baldado</i>					DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>1/21/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Helen M. Baldado, MD</i>					22e. ADDRESS <i>237 Florida Ave, Salisbury, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-26-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hutts Chapel</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Snow Hill, Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Norman F. Dennis</i>					ADDRESS <i>Snow Hill, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 28 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Therney McCreedy</i>				



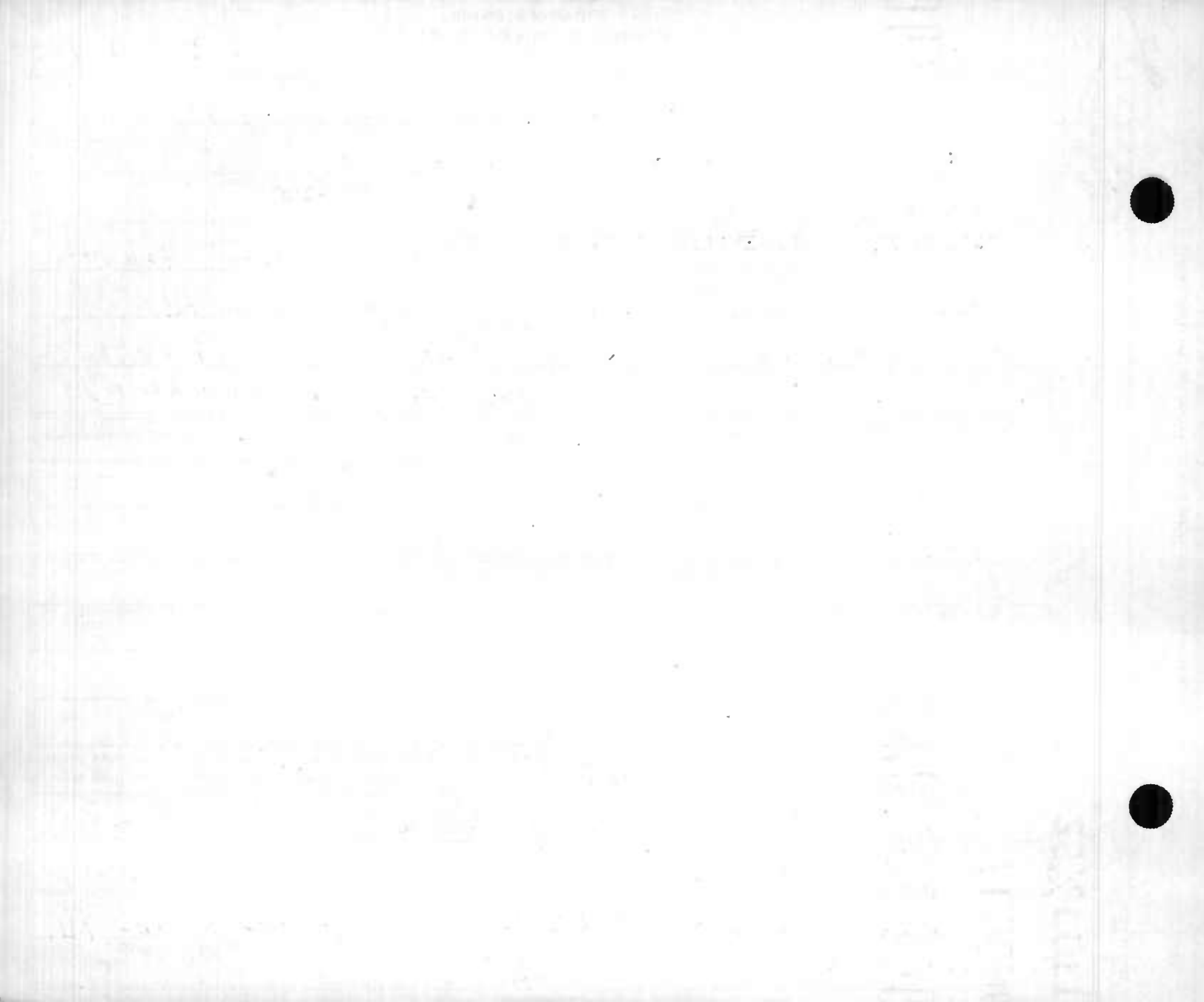
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002709			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) WILLIAM TOM CRICKETT JONES						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1980		2b. HOUR 30. M			
3. SEX M		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR AUG. 4, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WHITEHAVEN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.							
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PENINSULA GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY PLANT					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS # 12 SWAN RD.					
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE CRICKETT									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS DURNA JONES (ADD. SAME AS ABOVE)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1629 } DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lungs with metastasis													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 1/12/80 to 1/12/80 , that (I) (we) lost saw the deceased alive on 1/12/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Constante J Tan MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONSTANTE J TAN				22e. ADDRESS 547-D Riverside Dr., Salisbury, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-16-80		23c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY D.M. WHITEHAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE WHITEHAVEN Wicomico MD							
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel - Salisbury Md.				25a. DATE REC'D. BY REGISTRAR JAN 14 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy							

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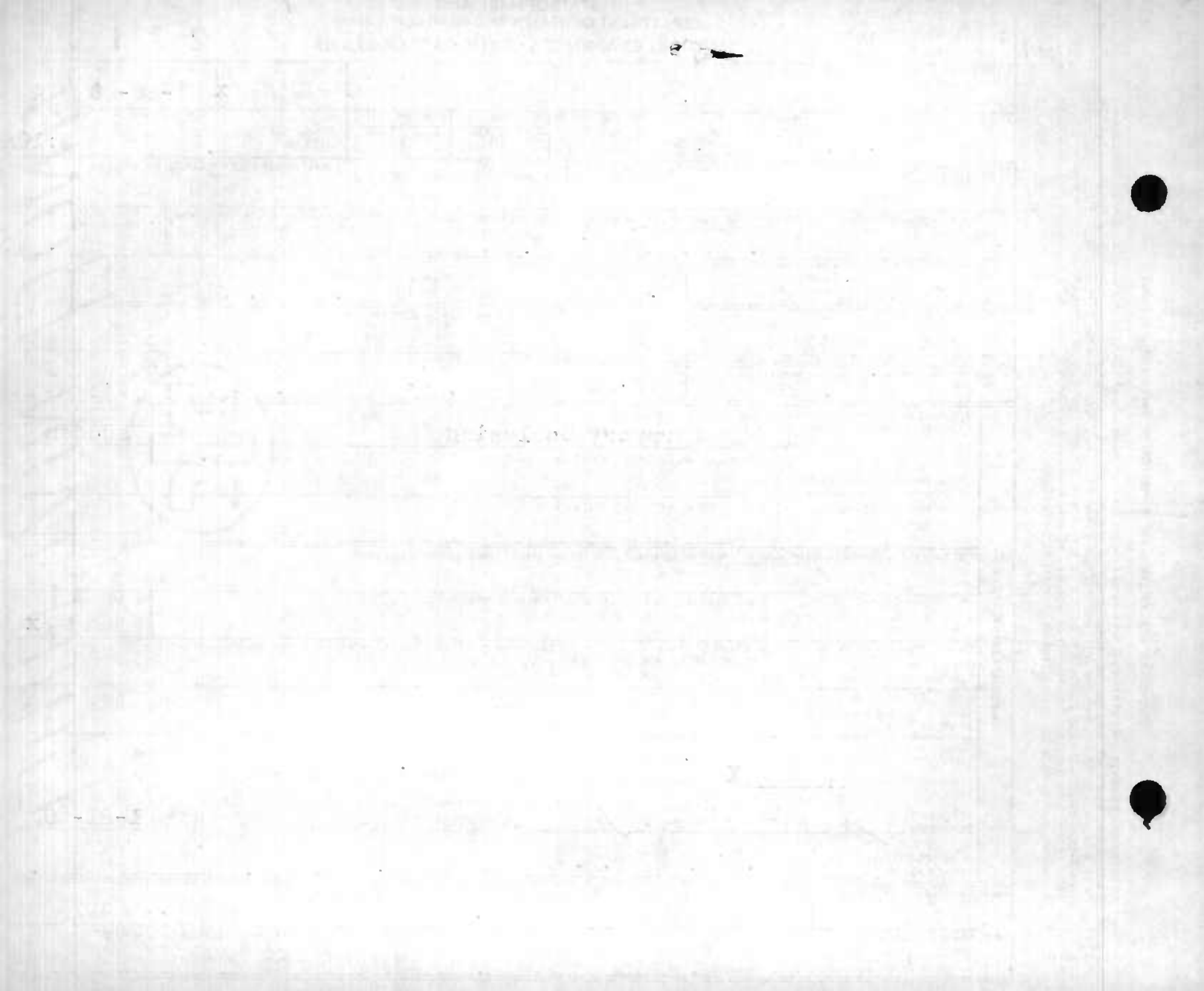


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REC. NO. 02710							
1- FOR STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		EST. MONTH DAY YEAR		2b. HOUR			
NORVAL						WILLIAM		KING				1-20-80		A		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		7d. HOUR			
Male		White		2/20/1919		60 YRS.						Jan. 20 1980		3:10A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Pennsylvania				USA								WICOMICO							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury				Rt. 6, Delmar US #13 North				Supervisor				Shirt Mfg. Co							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 6, US #13 North											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Roscoe William King				Rosabel Elizabeth Como															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
Yes				WW II				220-10-9706				Mrs. Madeline M. King (wife)				same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
<i>Earl L. Royer</i>				M.D. Deputy				MEDICAL EXAMINER				1-21-80							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Earl L. Royer, M.D.				409 Camden Ave. Salisbury, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				1/23/80				Wicomico Mem. Park				Salisbury, Wic., Maryland							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
HOLLOWAY FUNERAL HOME				Salisbury, Md.				JAN 23 1980				<i>Anthony McCreedy</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		6 0 0 2 7 1 1 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BEULAH		R.				LEMON		JANUARY 02, 1980		3:02p M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		3/23/1900		79 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				MD.	
SALISBURY		U.S.A.				WICOMICO					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
SALISBURY		DEER'S HEAD CENTER		RETIRED							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD.		WICOMICO		SALISBURY							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
EDWARD MARVER		ANNIE LOWES									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				MRS. PATRICIA OLIVER		SALISBURY, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Breast carcinoma - metastasis to brain</u>										8 years	
1749 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> to <u>1/2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Inja J. Hwang, M.D.						1/2/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
		P.O. Box 2018, Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		1/5/80		PARSONS CEM.		SALISBURY, MD.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
WILSON FUNERAL HOME		1/5/80		[Signature]							
NAME		ADDRESS									
WILSON FUNERAL HOME		SALISBURY, MD.									

RECEIVED
FEB 10 1960

TO: SAC, NEW YORK (100-100000) FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN U.S. PASSPORT; RE: NEW YORK TELETYPE TO BUREAU, 1/25/60.

RE: NEW YORK TELETYPE TO BUREAU, 1/25/60. (100-100000)

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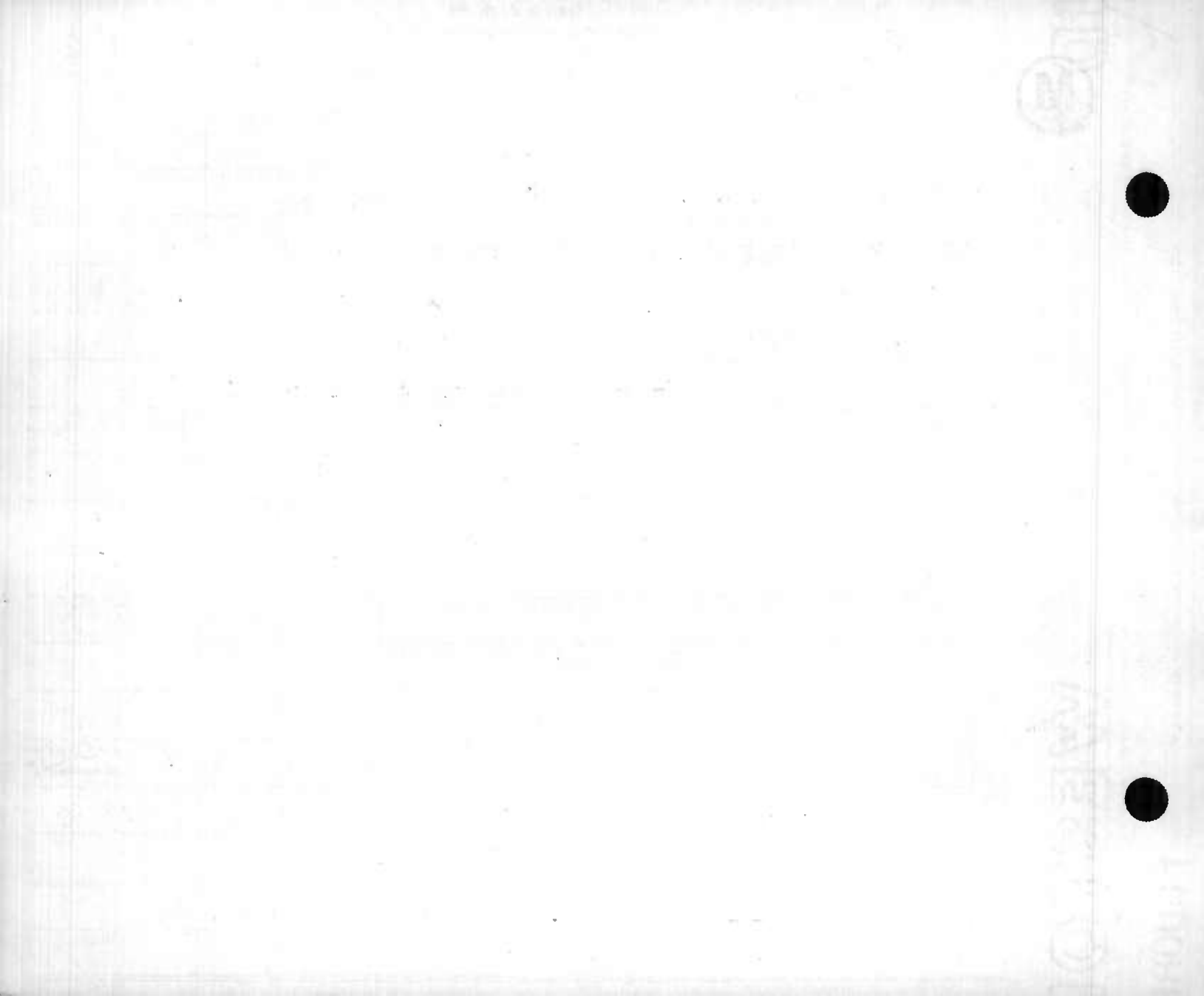
RE: NEW YORK TELETYPE TO BUREAU, 1/25/60. (100-100000)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 2 7 1 2	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Gilbert LEWERS				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 29 1980		2b. HOUR 0830 ^A			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.					
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Civil Service		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Virginia		13c. CITY OR TOWN Chincoteague		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS East Side					
14. FATHER'S NAME FIRST MIDDLE LAST Steven Lewers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Guillette									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 221-09-6518		17. INFORMANT ADDRESS Nola Lewers, Chincoteague, Virginia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <u>Small Cell Cancer of Lung</u> (c) <u>Asbestos Exposure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 1-10 19 80, to 1-29 19 80, that (1) (we) last saw the deceased alive on 1-28 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE C. R. Layton Sr.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-29-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. Layton				22e. ADDRESS PCHMC							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-1-80		23c. NAME OF CEMETERY OR CREMATORY Reynolds Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chincoteague, Virginia					
24. FUNERAL DIRECTOR NAME Sater Funeral Home, Chincoteague, Virginia				25a. DATE REC'D. BY REGISTRAR FEB 0 5 1980		25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8002713	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl W. Lineburger			2a. DATE OF DEATH MONTH DAY YEAR Jan. 19, 1980		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS 11 8
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Delmar	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 504 E. Pine St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Exide Corp.		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Delmar	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 504 E. Pine St.	
14. FATHER'S NAME FIRST MIDDLE LAST not available			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not available		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 163-10-9256	17. INFORMANT ADDRESS Louise M. Lineburger Delmar, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>arteriosclerotic heart disease</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>atrial fibrillation, compensated congestive heart failure</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 12/17</i> , 19 <i>79</i> , to <i>Dec. 17</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>12/17</i> , 19 <i>79</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did not)</i> view the body after death.					
22b. SIGNATURE <i>Rodney A. Wenrich</i>		DEGREE M.D.		22c. DATE SIGNED 1/23/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH		22e. ADDRESS KAY AVE. SALISBURY Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-1980	23c. NAME OF CEMETERY OR CREMATORY Parsons Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.
24. FUNERAL DIRECTOR NAME William M. Short		25a. DATE REC'D. BY REGISTRAR JAN 28 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

is heart failure

Dec. 13

HT

✓

KAY A.

Cem.

1971

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR												STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REC'D NO 2714			
1. DECEASED NAME (TYPE OR PRINT) CHARLES IRVING LLOYD						2a. DATE KNOWN OF DEATH ESTIMATED 1-15-80						2b. HOUR 8 A.M.															
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9/28/1922		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 15 1980				2d. HOUR 10:30 A.M.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.															
10. CITY OR TOWN OF DEATH Pittsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Main Street Ext.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk				12b. KIND OF BUSINESS OR INDUSTRY Grocery Store															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																											
13a. STATE Maryland				13b. COUNTY Wicomico				13c. CITY OR TOWN Pittsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Main Street Ext.											
14. FATHER'S NAME FIRST MIDDLE LAST Oren Wesley Lloyd						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Nace																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 218-24-6123				17. INFORMANT ADDRESS Mrs. Lois J. Lloyd (wife) same as 13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																											
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) Influenza																											
DUE TO, OR AS A CONSEQUENCE OF																											
(b) Chronic Obstructive Lung Disease																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER								DATE SIGNED 1-18-80															
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/18/80				23c. NAME OF CEMETERY OR CREMATORY Parsonsburg Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Parsonsburg, Wic., Md.															
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME				ADDRESS Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR JAN 21 1980				25b. REGISTRAR'S SIGNATURE <i>L. J. Helms</i>															

01-1-1 X

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01-1-1 X

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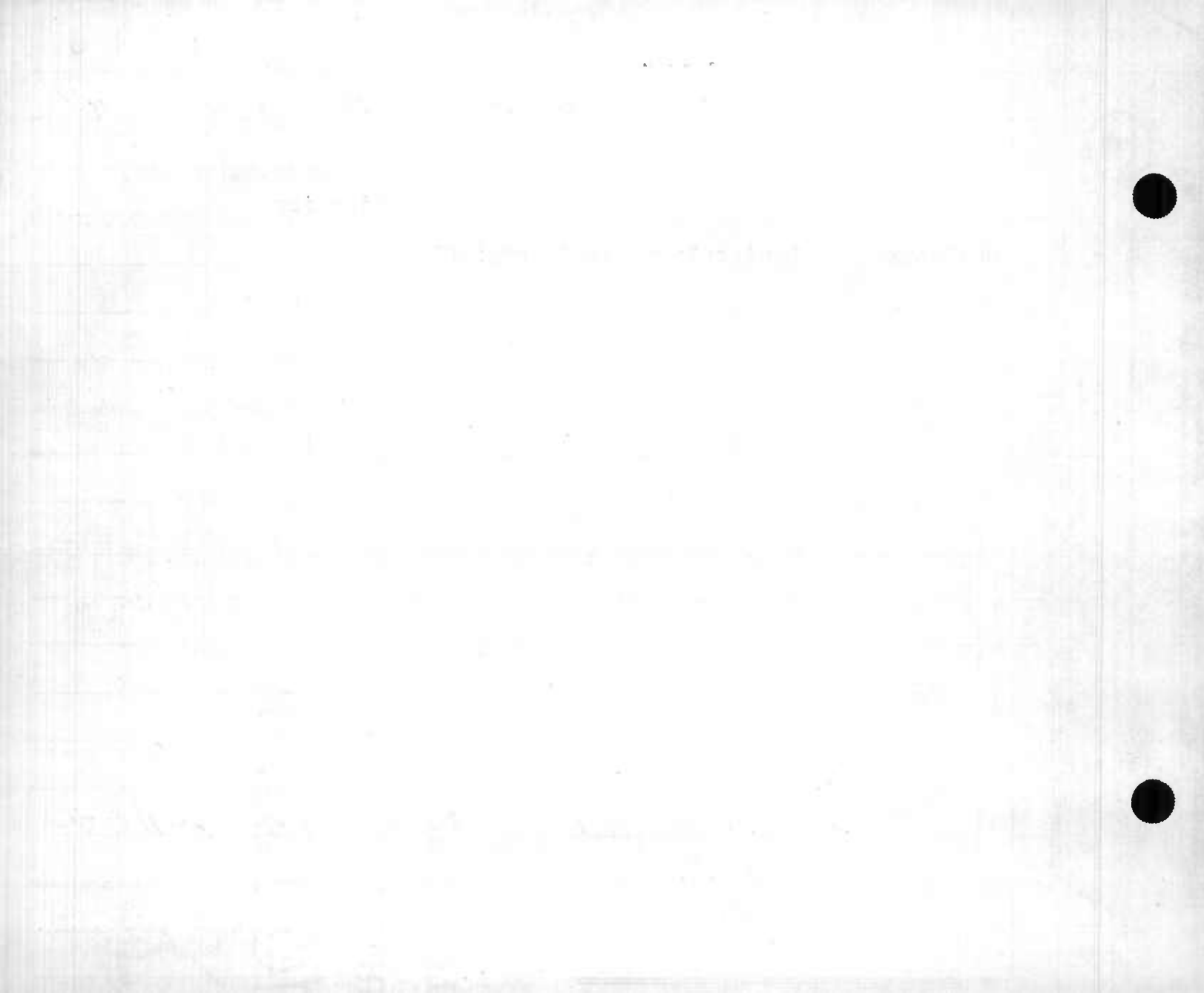
01-1-1 X

TO HOSPITAL SURVEILLING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		30002715				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Margaret Virginia						Malone		January 8 80		8:45 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 74 HRS. HOURS MIN.	
Female		White		Nov. 9, 1898		81 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Showell, Md.		USA				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				Housewife		none			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Wicomico		Salisbury				205 Honeysuckle Drive			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Severn Carey				Julia Downs							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17 INFORMANT (son)		ADDRESS			
No				215-38-1145		Mr. Russell P. Malone, Salisbury, Md.		1409 Arbutus Dr.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4140 8 peritonsillar abscess											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 1/8/80 to 1/8/80, that (I) (we) lost saw the deceased alive on 1/8/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
W. Ben Horner M.D.								1/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
W. Ben Horner, M.D.				Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/12/80		Parsons Cemetery		Salisbury, Wicomico, Md.					
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME, Salisbury, Md.						JAN 11 1980		[Signature]			

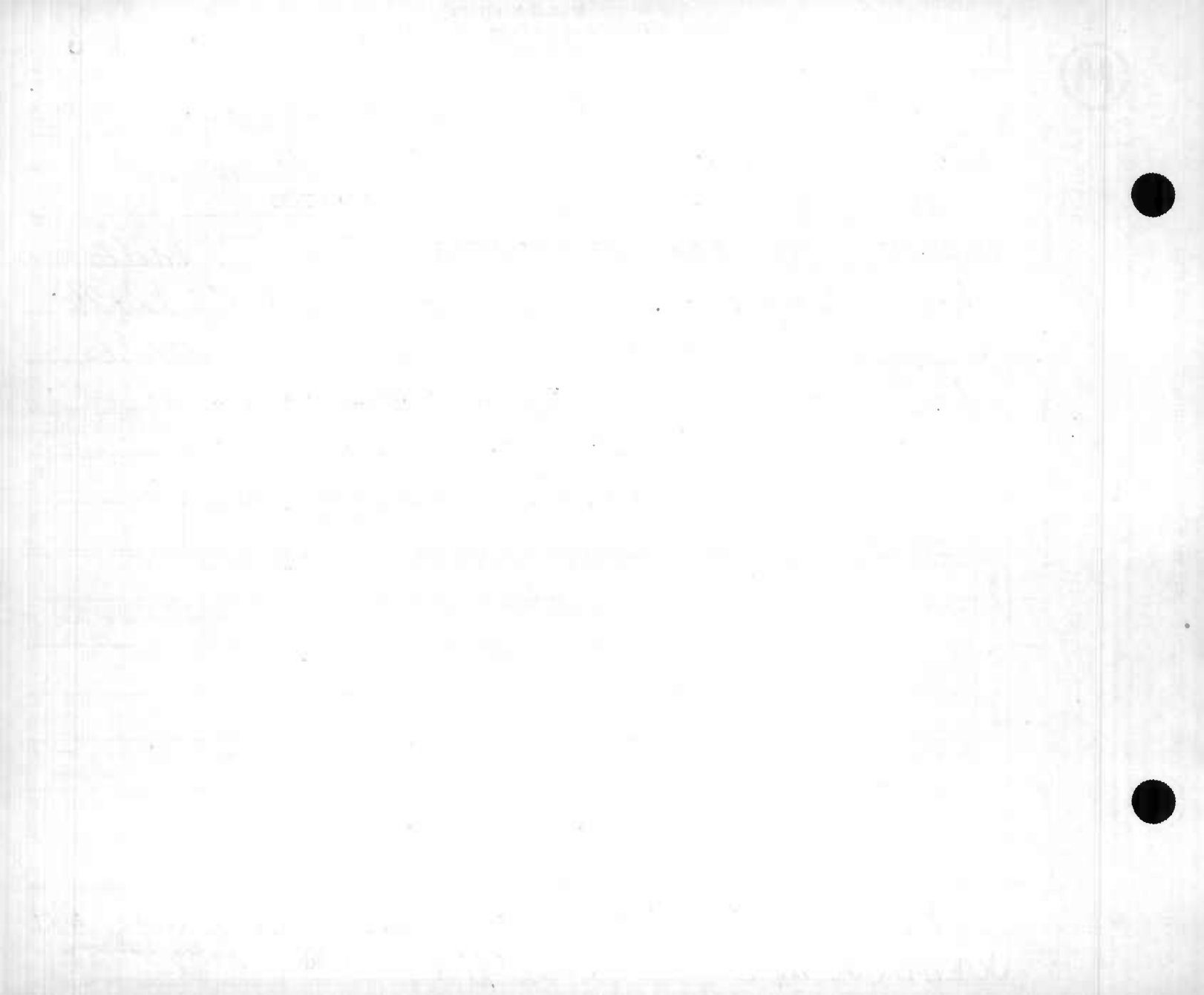


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 80 02716						
1. DECEASED NAME (TYPE OR PRINT) <u>SARAH LOUISE MANUEL</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>January 21, 1980</u>			2b. HOUR <u>10:00 P</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>8 19 38</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>41</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>WICOMICO</u> MD.			
10. CITY OR TOWN OF DEATH <u>SALISBURY</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>PENINSULA GENERAL HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>COOK</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Bd of Education</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>		13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Snow Hill</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Rt. #1 Box 46</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Fisher</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lola Ennis</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>218-406513</u>		17. INFORMANT <u>Wilbert Manuel</u>		ADDRESS <u>Same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> <u>1729</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malnutrition resulting from lung metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>1/21</u> , 19 <u>80</u> , to <u>1/21</u> , 19 <u>80</u> , that (1) was lost saw the deceased alive on <u>1/21</u> , 19 <u>80</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) has (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph A. Grassi</u>						DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph A. Grassi</u>						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>1-25-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake U.M. Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Girdletree Wicomico MD</u>		
24. FUNERAL DIRECTOR NAME <u>JOLEY MEMORIAL Chapel</u>			ADDRESS <u>Rt. #2 Jersey Rd Salisbury, MD</u>		25a. DATE RECD. BY REGISTRAR <u>JAN 25 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

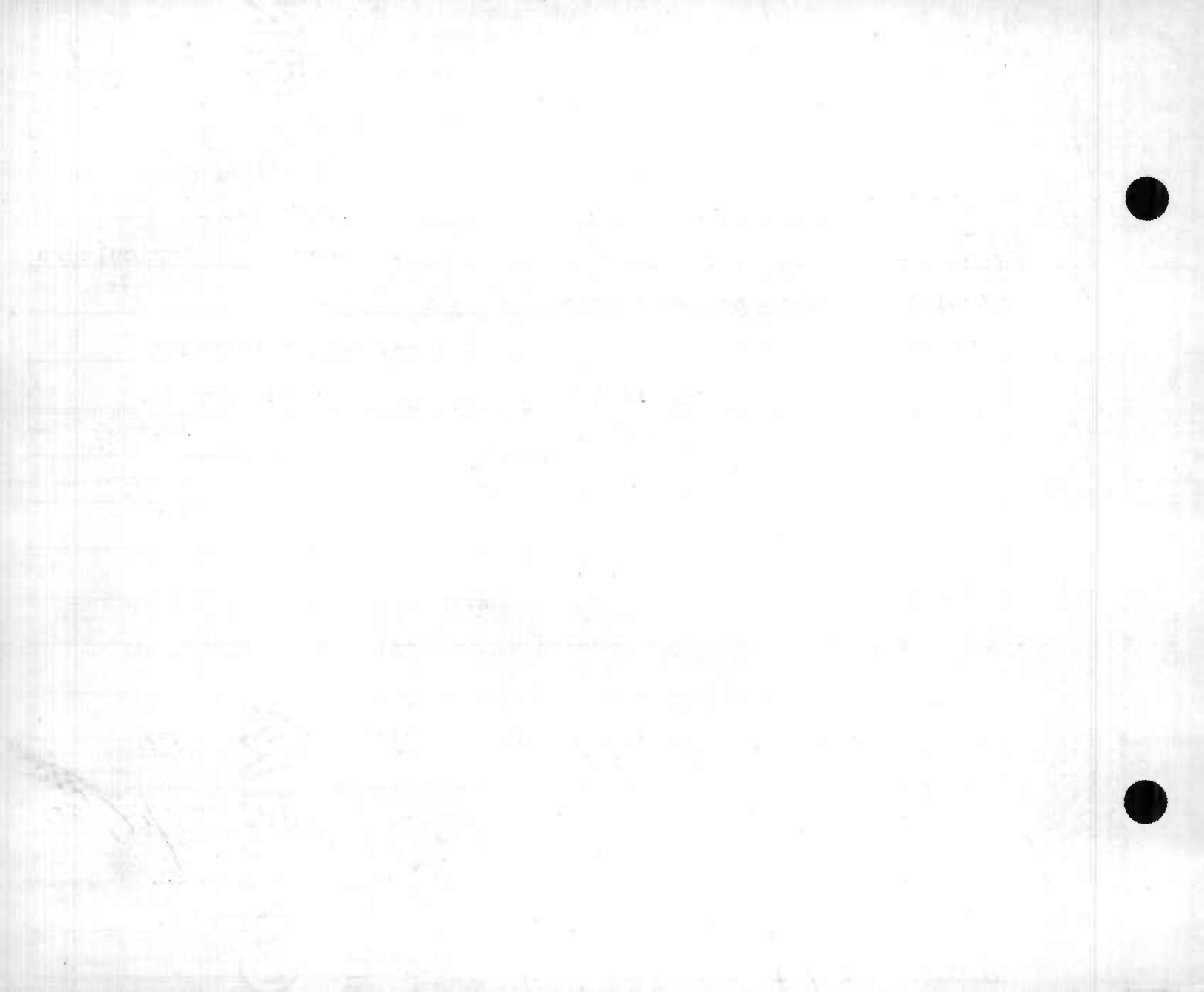


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 0 0 2 7 1 7				REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR AM PM	
Milton						MATTHEWS		1-14-80		5:10 AM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
M		W		11-14-94		85 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.				Wicomico County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Salisbury Nursing Home						Farmer		Agriculture	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Virginia		Northampton		Machipongo							
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Thomas F. Matthews				Rebecca Watson Matthews							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No				228-48-5654		Mrs. Joe Outten, Salisbury, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4340</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yes</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>2/1/80</u> 19 <u>78</u> , to <u>4/14</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/14</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Earl M. Boardsley</u> DEGREE <u>MD</u>										22c. DATE SIGNED <u>1/14/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Earl M. Boardsley</u>										22e. ADDRESS <u>Rt. 50 & Civic Ave. Salisbury, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>										23b. DATE <u>11/16/80</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Johns</u>										23d. LOCATION CITY OR TOWN COUNTY STATE <u>Johnsontown, Va.</u>	
24 FUNERAL DIRECTOR NAME <u>James N. Fay</u> ADDRESS _____										25a. DATE REC'D. BY REGISTRAR <u>JAN 29 1980</u>	
										25b. REGISTRAR'S SIGNATURE <u>Henry McQuiddy</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 80 02718							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
THELMA Francis		McIntyre						January 24 1980	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		Jan. 23, 1933		47 YRS.		5:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Salisbury, Md.		USA				Wicomico		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hosital				Housewife		none	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		300 Hall Drive	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Albert Benjamin Crouch					Eva Willey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		220-26-8426		Mr. James O. McIntyre (husband) same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intervascular Hemorrhage</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from <u>1-19-1980</u> to <u>1-24-1980</u> , that (I) (we) last saw the deceased alive on <u>1-24-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>James H. Clifford MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
JAMES H. CLIFFORD MD				#12 MEDICAL CENTER Salisbury MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1/27/80		Allen Cemetery		Allen, Wic., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Holloway Funeral Home, Salisbury, Md.				JAN 29 1980		<u>Ritzy McHenry</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

8 0 0 2 7 2 0

1. DECEASED-NAME (Type or print)		First HENRY	Middle E.	Last MORRIS	2a. DATE OF DEATH Month JAN. Day 14 Year 1980		2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 25, 1910		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.				
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. CITY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER CANAL WOOD		
14. FATHER'S NAME First EDWIN Middle MORRIS Last				15. MOTHER'S MAIDEN NAME First ANNA Middle SIBERT Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS MARY MORRIS (WIFE)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of lung DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph A. Grasso					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Joseph A. Grasso					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE 1/17/80		23c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEM.		23d. LOCATION (City or Town) (County) (State) PRINCESS ANNE, MD.				
24. FUNERAL DIRECTOR LEVIN R. WILSON					ADDRESS PRINCESS ANNE, MD.		25a. REGISTRATION DATE JAN 21 1980		25b. REGISTRAR'S SIGNATURE Anthony J. Chesley	

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	0 2 7 2 1		
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR		2c. DATE OF ESTI-MATED DEATH		2d. HOUR	
		FIRST		MIDDLE		LAST		MONTH		DAY		YEAR		M	
		Lonnie		Vickers		Morrison		1-17		180		11A		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Female		White		1-13, 1896		84 YRS.		MONTHS		DAYS		1-17		1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
Georgia		U.S.A.						X				Wicomico			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury		411 Virginia Ave.,		Retired		Nurse									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Wicomico		Salisbury		YES X NO		411 Virginia Ave.,							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT							
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST					
John		J.		Vickers		Una		M.		Whiddon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS									
No		258-48-6949		Mariuna Morrison		Salisbury, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4413		Hemorrhage		Ruptured Abdominal Aortic Aneurysm		Minutes									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21a. INJURY OCCURRED WHILE AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21c. LOCATION		CITY OR TOWN		COUNTY		STATE					
21a. INJURY OCCURRED WHILE AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21c. LOCATION		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion							
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED											
Dr. Earl L. Royer		Deputy		1-18-1980											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Dr. Earl L. Royer		409 Camden Ave.,		Salisbury, Maryland		21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
Burial		1-19-1980		Bonaventure Cemetery		Savannah, Chatham		Georgia							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Hill-Baker-Bounds		JAN 21 1980		Hill-Baker-Bounds											

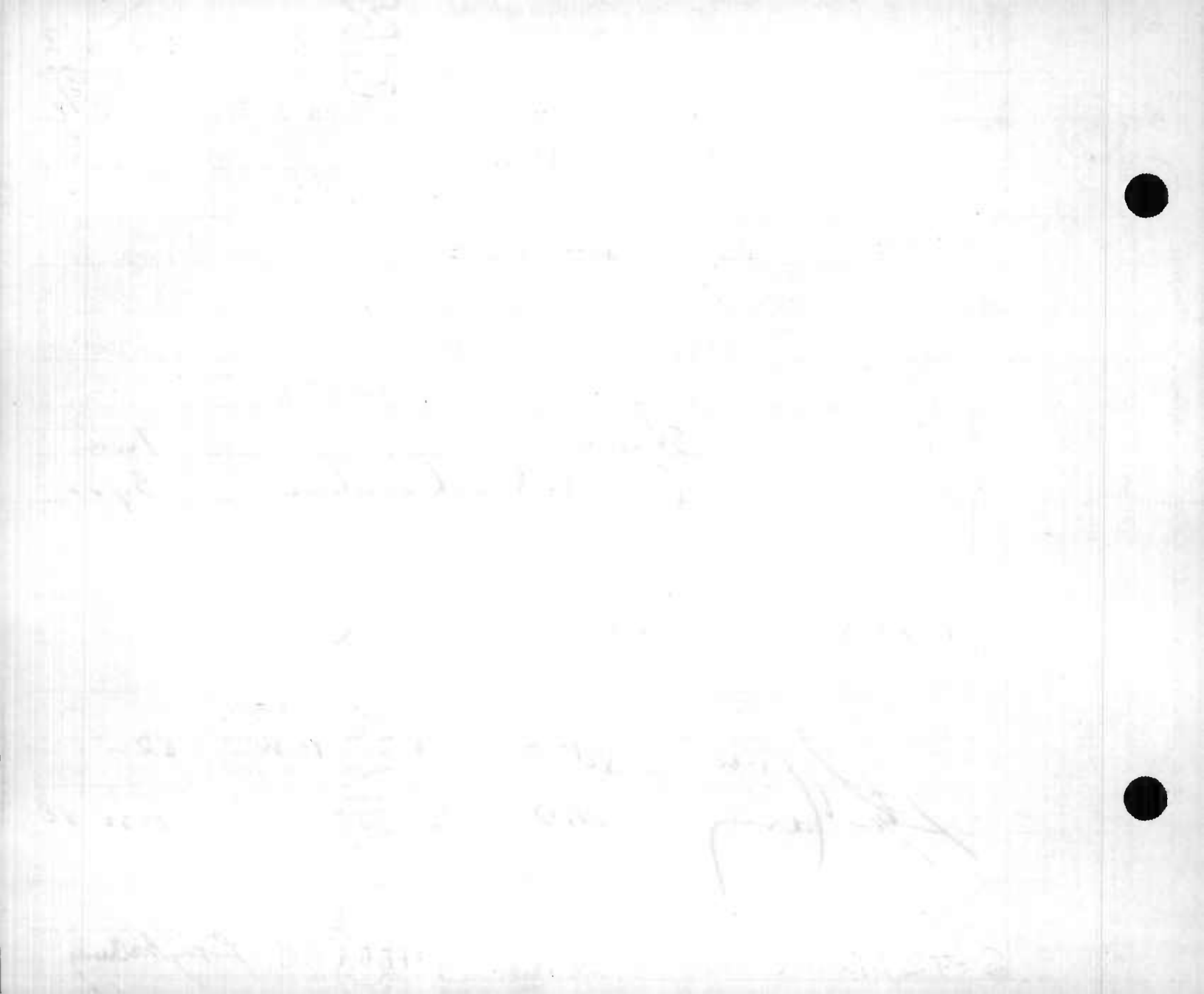
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(VR AT 15 ME (5))
15M 7/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8002722			
1. DECEASED NAME (TYPE OR PRINT) MEREDITH W. Nicholson				2a. DATE OF DEATH MONTH DAY YEAR January 30, 1980			
1. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1924		2b. HOUR 5:15 P.M.	
3. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 55 YRS.		8. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (IF) INDUSTRY Electronics Engineer	
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Nicholson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Schnatterly		16. STREET ADDRESS 1503 Market Street			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		18b. SOCIAL SECURITY NO. WW 2		17. INFORMANT ADDRESS Elsie E. Nicholson Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 3 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION 1-23-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral stenosis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 1-30-80 to 1-30-80, that (I) (we) last saw the deceased alive on 1-30-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE [Signature] DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-30-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/80		23c. NAME OF CEMETERY OR CREMATORY Sunny Ridge Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md.	
24. FUNERAL DIRECTOR NAME Scott S. Melson				ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR FEB 04 1980	
				25b. REGISTRAR'S SIGNATURE [Signature]			

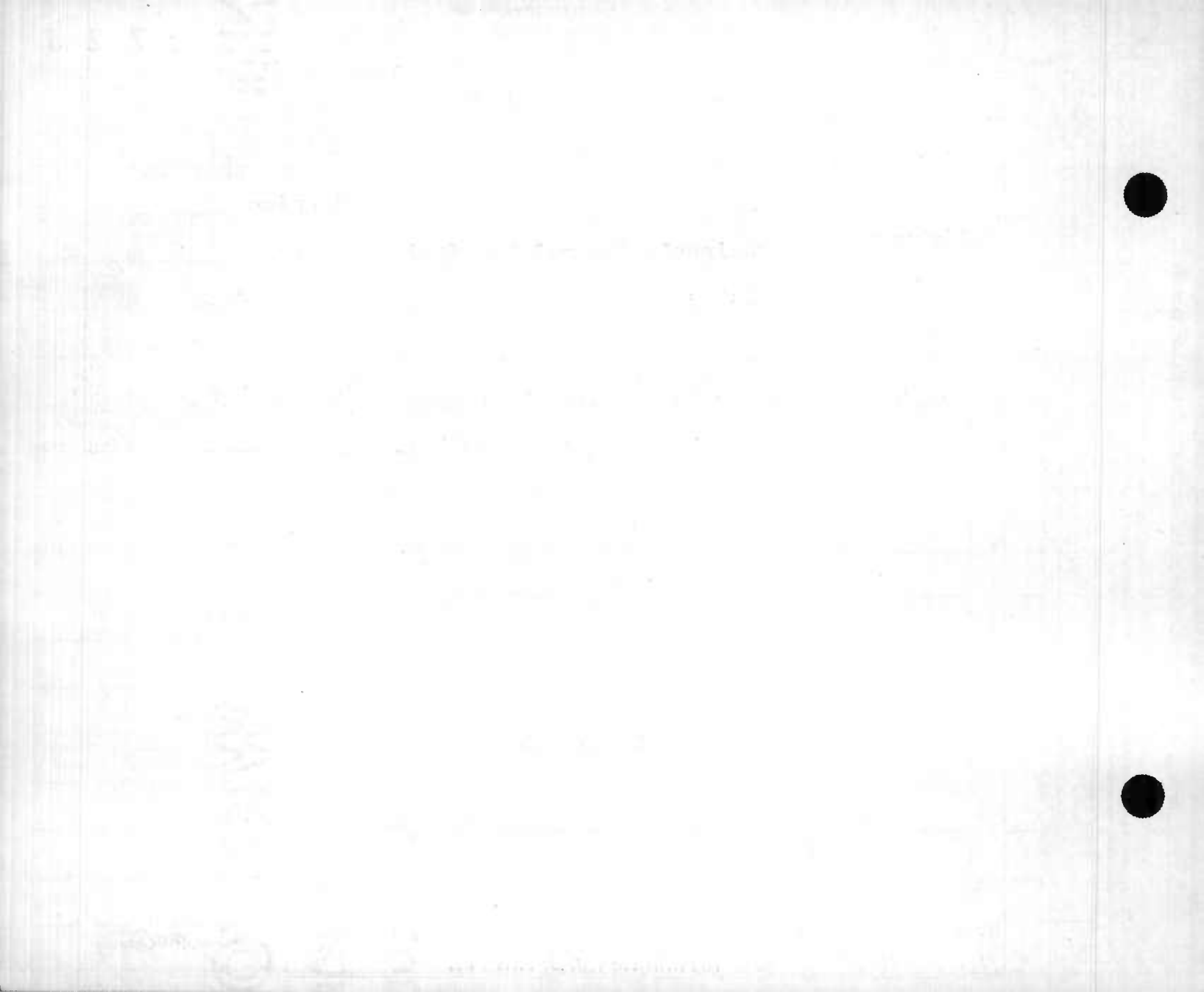


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 7 2 3 REG. NO.					
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) Donald Alfred Parent										2a. DATE OF DEATH MONTH DAY YEAR January 20 1980				2b. HOUR 6:50 M	
3. SEX Male			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 29 1931			6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.						
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Surveyor			12b. KIND OF BUSINESS OR INDUSTRY Surveying Land						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Worcester 13c. CITY OR TOWN Berlin										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 200 West Street			
14. FATHER'S NAME FIRST MIDDLE LAST Edmund - Parent					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice - Poirier										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 006-26-4981		17. INFORMANT ADDRESS Phyllis I. Parent, 200 West St Berlin, Md.								
II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH Few hours					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Extensive anterior wall MI										24 hr					
DUE TO, OR AS A CONSEQUENCE OF (c) Occlusive disease of 3 vessels										years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension - Hial Hernia															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 1/19/80 19____, to 1/20/80 19____, that (I) (we) last saw the deceased alive on 1/20/80 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE BAL AGARWAL DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAL AGARWAL					22e. ADDRESS P.G.H										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/24/80		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Wor. Md.							
24. FUNERAL DIRECTOR NAME Anna A. Burkhage ADDRESS 108 Williams St. Berlin, Md.					25. DATE RECD. BY REGISTRAR JAN 28 1980			26. REGISTRAR'S SIGNATURE [Signature]							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) HARVEY W. PAYNE						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1-17-80 9:55 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 6 DAY 4 YEAR 10	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD 1-17-80		2d. HOUR 11	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired - Eng.		12b. KIND OF BUSINESS OR SERVICE Civil	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rd. #2, Box 145	
14. FATHER'S NAME FIRST William MIDDLE H. LAST Payne					15. MOTHER'S MAIDEN NAME FIRST Sallie MIDDLE Carey LAST Carey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW2 Navy		17. INFORMANT Mabel Payne Pocomoke City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Diabetes Mellitus (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Earl L. Royer</i>			TITLE (SPECIFY) Deputy			DATE SIGNED 1-18-80			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.			ADDRESS 409 Camden Ave., Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/80		23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md.			
24. FUNERAL HOME OR ADDRESS Watson-Melson Funeral Home, Pocomoke, Md.						25a. DATE REC'D. BY REGISTRAR JAN 24 1980		25b. REGISTRAR'S SIGNATURE <i>John M. Melton</i>	

X

100-10-500

100-10-500

X X

X

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 7 2 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE C. LAST PENNEWELL						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30, 1980			2b. HOUR 1:30 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 19 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO, MD.					
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deers Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Poultry plant		12b. KIND OF BUSINESS OR INDUSTRY Poultry processing			
USUAL RESIDENCE (IF NURSING HOME FOR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Worcester 13c. CITY OR TOWN Berlin						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 204 Broad St.			
14. FATHER'S NAME FIRST MIDDLE LAST Tom Tracey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Cooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT John M. Powell				ADDRESS Green Meadows Trailer Park 19940 Delmar, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 514- DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 20, 19 79 to Jan. 30, 19 80, that I (we) last saw the deceased alive on Jan. 30, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (do not) view the body after death.											
22b. SIGNATURE Inja J. Hwang						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01/30/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja J. Hwang, M.D.						22e. ADDRESS P.O. Box 2018, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/80		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Wor Md.		25a. DATE REC'D. BY REGISTRAR FEB 5 1980			
24. FUNERAL DIRECTOR NAME Anna A. Budge ADDRESS 108 Williams St. Berlin, Md.						25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 02726	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie MAE PITTS						2a DATE OF DEATH MONTH DAY YEAR January 27, 1980		2b HOUR 5:20 PM	
3 SEX F		4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR 8 30 02		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b KIND OF BUSINESS OR INDUSTRY Housewife			
13a STATE MD.		13b COUNTY Worcester		13c CITY OR TOWN Berlin		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt #2 Box 579			
14 FATHER'S NAME FIRST MIDDLE LAST George MORRIS				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE TINGLE							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO. 220-28-06		17 INFORMANT ADDRESS EDWARD L. PITTS (Add. SAME AS Above)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia 436- DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular accident w/ly (c) hemiplegia + aphasia + dysphagia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Nancy W. Tustin, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-27-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NANCY W. TUSTIN, M. D.						22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-2-80		23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md.			
24. FUNERAL DIRECTOR NAME Solley Memorial Chapel, Salis. Md.						25a. DATE REC'D. BY REGISTRAR JAN 30 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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0 5 7 5

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

January 2, 1964

MEMO

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

Reference is made to New York letter to Bureau dated 12/18/63.

ADH

Very truly yours,

[Illegible]

Enclosure

[Illegible]

[Illegible]

[Illegible]

Very truly yours,

[Illegible]

[Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02727	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE RAY PORTER						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-31-80		2b. HOUR AM PM AM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 8 07	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 72	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-31-80 19		2d. HOUR AM PM 8 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 601 Regency Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier		12b. KIND OF BUSINESS OR INDUSTRY Postal			
13a. STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 601 Regency Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Porter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Lankford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 221-07-5638		17. INFORMANT ADDRESS (son) P.O. Box 1365, Kent Cir Mr. Robert G. Porter, Salisbury, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 1-31-80			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/80		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens, Salisbury, Wic., Maryland				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR FEB 4 1980		25b. REGISTRAR'S SIGNATURE <i>Robert G. Porter</i>			

100 700

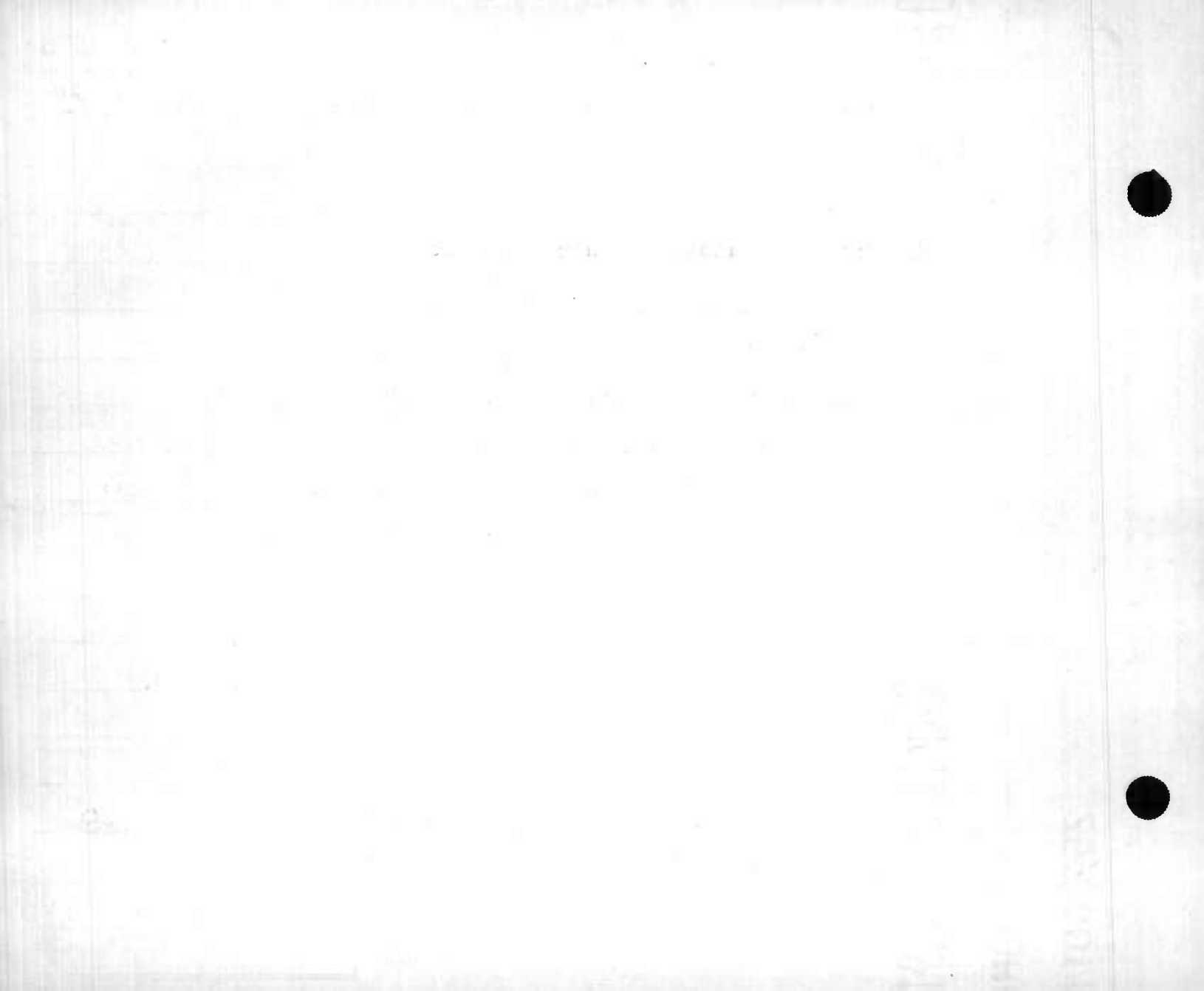
TO HOSPITAL OR ATTENDING PHYSICIAN The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 0 2 7 2 8 REG. NO.	
1. FOR STATE REGISTRAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward POWELL		2a. DATE OF DEATH MONTH DAY YEAR January 1, 1980	
3 SEX Male		2b. HOUR 1:20 M	
4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 12 93	
6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Willards, Md.	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		10. CITY OR TOWN OF DEATH Salisbury	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman	
12b. KIND OF BUSINESS OR INDUSTRY Seafood		13a. STREET ADDRESS in village	
14. FATHER'S NAME FIRST MIDDLE LAST George E. Powell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Ellen Tingle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 218-05-8571	
17. INFORMANT ADDRESS Mrs. Eva Mae Powell (wife) same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Shock 410- DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS HRS HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from 1/1 , 19 80 , to 1/1 , 19 80 , that (s/he) lost saw the deceased alive on 1/1/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s/he) (did) (did not) view the body after death.			
22a. SIGNATURE Donald M. Ann		22b. DEGREE MD	
22c. DATE SIGNED 1/1/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. M. WOOD	
22e. ADDRESS P. F. H.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/80	
23c. NAME OF CEMETERY OR CREMATORY Parsons family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pittsville, Wic., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 8 1980	
25b. REGISTRAR'S SIGNATURE [Signature]			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REPEAT EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 7 2 9

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		7b. HOUR	
		SARAH A. POWELL				2b. DATE ESTI- MATED		1-9-80		8:10P	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Female	White	12 23 1890	89 YRS.					1-9-80		11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Md.		U.S.A.				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital		Housewife		Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Worcester		Berlin				Rt. 1, Box 42			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James H. Laws		Leah Catherine Jarmon									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		218-34-9524		Lawrence A. Powell		Pocomoke City, Md. 906 Market St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm 4415 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy MEDICAL EXAMINER						DATE SIGNED 1-10-80			
EXAMINER'S NAME (TYPE OR PRINT)		Earl L. Royer, M.D.						ADDRESS 409 Camden Ave., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/12/80		St. Johns Cemetery		Powellville, Wicomico Md.					
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE					
A. Burbage		108 Williams St. Burbage Funeral Home, Berlin, Md.		JAN 4 1980		L. J. [Signature]					

A

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 7 3 0

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ARTHUR S. PRUITT			2a. DATE OF DEATH MONTH 1 DAY 20 YEAR 80			2b. HOUR 1:15 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 10 YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Angles, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
13a. STATE MD		13b. COUNTY Wicomico		13c. CITY OR TOWN Nantuxet							
14. FATHER'S NAME FIRST Stephen MIDDLE Pruitt				15. MOTHER'S MAIDEN NAME FIRST Evelyn MIDDLE Evans LAST Evans							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-32-0894		17. INFORMANT ADDRESS Brenda Adkins, 521156 Ave, Nantuxet, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous from Prostate 2030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Myeloma (c) Chronic obstructive Pulmonary Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPS YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Mitchell, MD				DEGREE MD				22c. DATE SIGNED 1/21/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mitchell, MD				22e. ADDRESS POB 2378 Salisbury, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/80		23c. NAME OF CEMETERY OR CREMATORY Tuxedo Cem.		23d. LOCATION CITY OR TOWN Nantuxet COUNTY MD STATE MD					
24. FUNERAL DIRECTOR NAME C. J. Smith, Bivalue, MD ADDRESS				25a. DATE REC'D. BY REGISTRAR JAN 25 1980		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02731	
1. DECEASED NAME (TYPE OR PRINT) Hubert Pryor						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 8 1980		2b. HOUR M			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 16, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 8 1980		2d. HOUR 10:05 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland						13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS Rt. 1, Box 21A					
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 417-16-2922AI		17. INFORMANT ADDRESS Maryland 21643 Joseph Newcomb, Rt. 1, Box 21A, Hurlock.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound to head (rifle) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 4:30 P.M. 1 4 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) subject shot						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Skinners Run Rd. Hurlock, Dorchester, MD						
22. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>			TITLE (SPECIFY) Deputy Chief					DATE SIGNED 1/10/80			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Frampton-Hawkins Funeral Home, 216 N. Main St.			25a. DATE REC'D. BY REGISTRAR 1 JAN 16 1980			25b. REGISTRAR'S SIGNATURE <i>Robert H. Smith</i>					

BP

THE UNIVERSITY OF CHICAGO
LIBRARY

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1981-1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

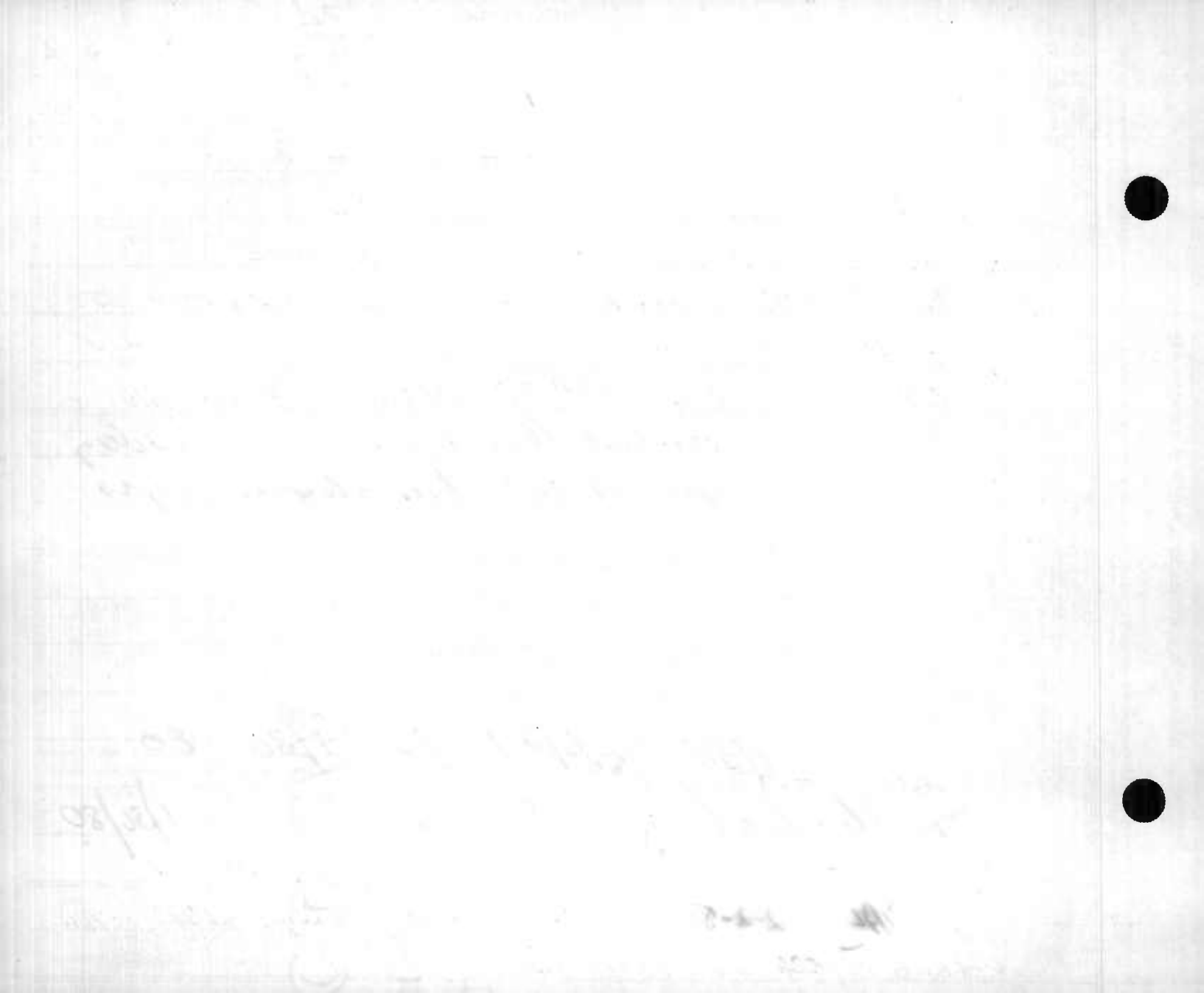
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		35		36		37		38	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Bertie		A.		QUILLIN				1-30-80	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
F		W		1-16-1882		98		9:45AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.		U.S.				Wicomico County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury, Md.		Salisbury Nursing Home		AT HOME					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD		WICOMICO		BERLIN				2 WASHINGTON ST.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
JRA		P. BOWEN				210-09589		E.B. QUILLIN BERLIN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4340		Cerebral Thrombosis		Generalized atherosclerosis		2 days		yes.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/27/80 to 1/30/80, that (I) (we) lost		22b. DATE SIGNED		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		22g. DATE REG'D BY REGISTRAR		22h. REGISTRAR'S SIGNATURE			
EARL M. BEARDSLEY, M.D.		CIVIC AVE, & RT. 50, SALISBURY, MARYLAND		FEB 13 1980		M. J. McCready			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		2-2-80		EVERGREEN CEM		BERLIN, WICOMICO, MD.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REG'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
V. L. RICH FUNERAL HOME		BERLIN, MD.		FEB 13 1980		M. J. McCready			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 7 3 3
REG. NO.

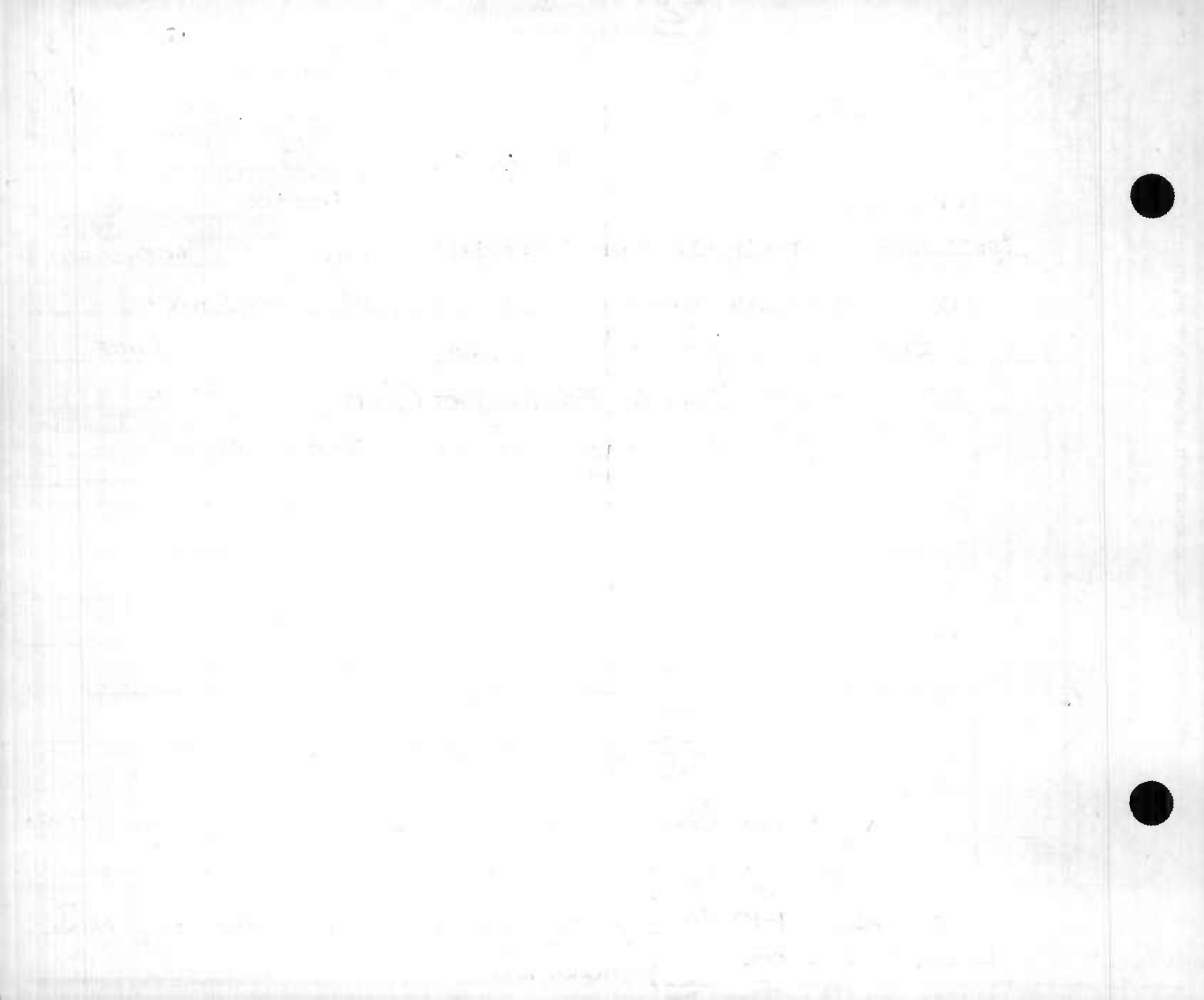
1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CALVIN L Quillen			2a DATE OF DEATH MONTH DAY YEAR January 16, 1980		2b HOUR 6 45 A M
3 SEX male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 01 07		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin, Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE Md 12b COUNTY Worcester 12c CITY OR TOWN Berlin		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS 518 Flower Street	
14 FATHER'S NAME FIRST MIDDLE LAST O B E D Quillen		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA LANE		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b SOCIAL SECURITY NO. 197-01-2395	
17 INFORMANT Margaret Quillen		ADDRESS Same			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF Colon. 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) BRONCHO PNEUMONIA			
19a DATE OF OPERATION JAN 4, 1980	19b CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from JAN 3 19 80 , to JAN 15 19 80 , that (I) (we) last saw the deceased alive on JAN 15 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE John A. Bartkovich MD		22c DATE SIGNED Jan 16, 1980	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. BARTKOVICH		22e ADDRESS DOGE 3A - MEDICAL CENTER SALIS. MD.	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 1-19-80	23c NAME OF CEMETERY OR CREMATORY Gouldtown Mem. Park	23d LOCATION CITY OR TOWN COUNTY STATE Brickton, Cumb. Co N.J.
24 FUNERAL DIRECTOR NAME Lively Funeral Home ADDRESS 656 E. Commerce St. Brickton, N.J.		25a DATE REC'D. BY REGISTRAR JAN 23 1980	25b REGISTRAR'S SIGNATURE Anthony McCready



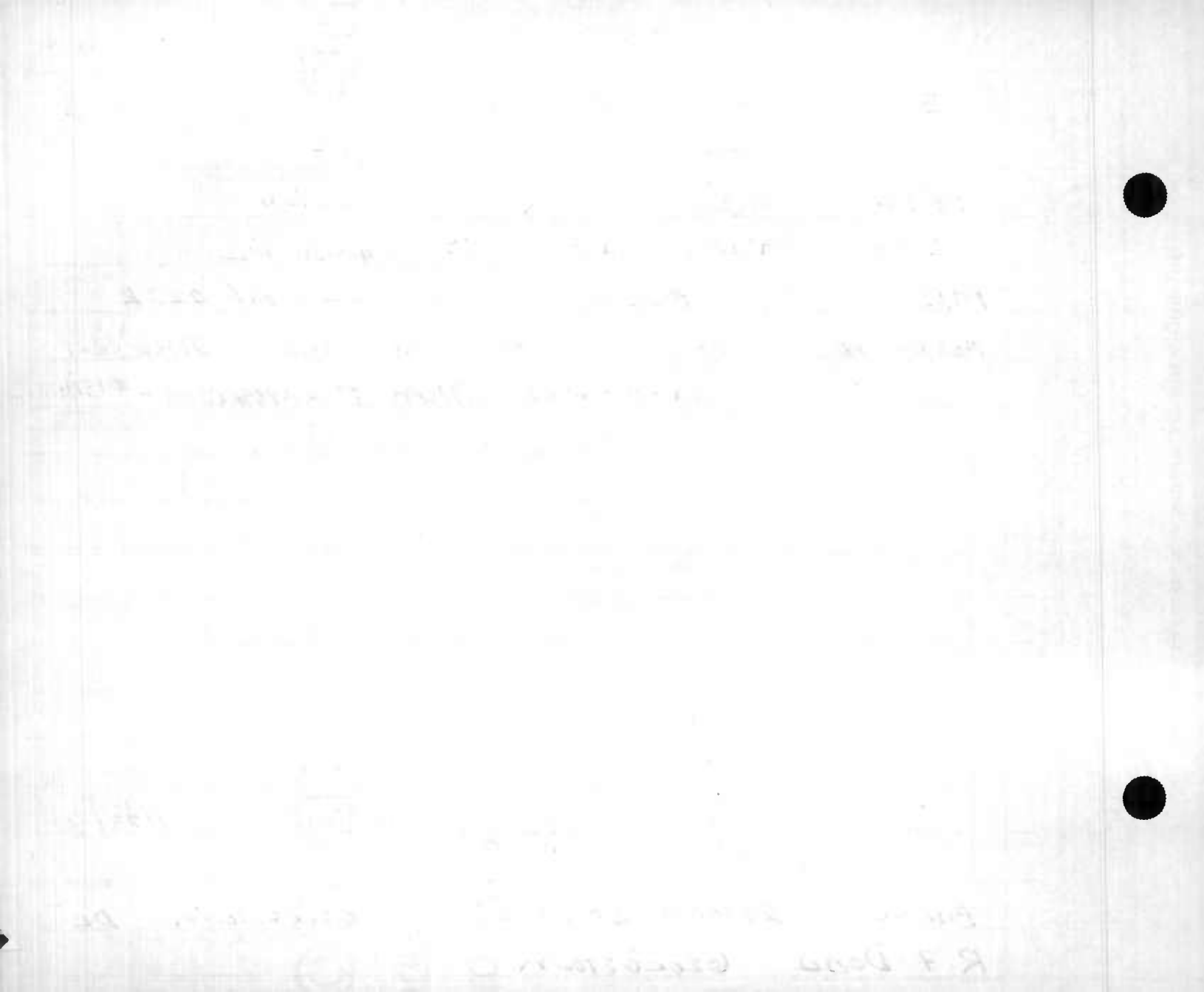
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 7 3 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) BESSIE PALMLEY RICHARDSON										2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1980				2b. HOUR 1:40 M	
3. SEX Female		4. RACE CAY		5. DATE OF BIRTH MONTH DAY YEAR 17 JUL 91		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.									
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY DOR		13c. CITY OR TOWN BERLIN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 2 BOX 2838							
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER JACKSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALBERTA DOWNS JACKSON											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 216-88-4548				17. INFORMANT ADDRESS RALPH I RICHARDSON - #13AB002							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 1/18 19 80 to 1/23 19 80 , that (I) (we) lost saw the deceased alive on 1/22 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE M. Ben Horner MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/23/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. BEN HORNER				22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 27 JAN 80		23c. NAME OF CEMETERY OR CREMATORY ST PAULS		23d. LOCATION CITY OR TOWN COUNTY STATE GEORGETOWN DE							
24. FUNERAL DIRECTOR NAME R. F. DODD						ADDRESS GEORGETOWN		25a. DATE REC'D. BY REGISTRAR FEB 10 1980		25b. REGISTRAR'S SIGNATURE Tracy McCreedy					

BP _____



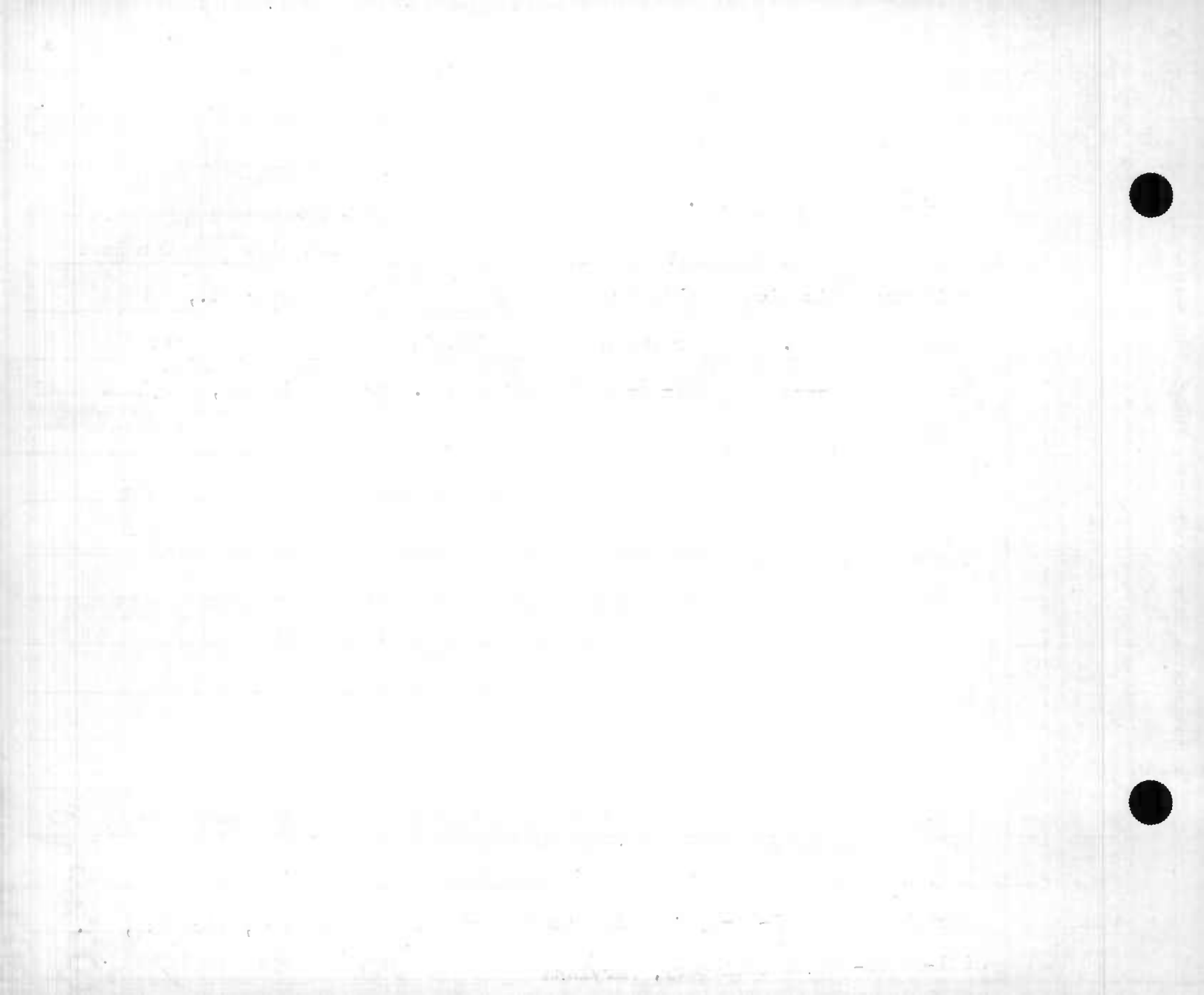
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 0 0 2 7 3 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marie Bradshaw RINGGOLD			2a. DATE OF DEATH MONTH DAY YEAR 1-17-80			2b. HOUR 8:45 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-27-96		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Salisbury		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 800 Hanover St.,	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas P. Bradshaw				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathie Rowe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-36-2236		17. INFORMANT 11901 Essex Drive Mrs Jane R. Ford Salisbury, Maryland 21801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ht failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) A.C.U.D.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Joseph C. Fitzgerald				DEGREE M.D.				22c. DATE SIGNED 1-17-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. JOSEPH C. FITZGERALD				22e. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-1980		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park Salisbury, Wicomico, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR JAN 21 1980	
24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds				ADDRESS Salisbury, Maryland				25e. REGISTRAR'S SIGNATURE Hickory McCready	

BP _____



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DHMH - 16 50M 7/77
(VR A 15 (4))

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 0 2 7 3 6 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry R. Robinson						2a. DATE OF DEATH MONTH DAY YEAR January 17, 1980		2b. HOUR 8:15 p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 19, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 4 28	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Mardela		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 109	
14. FATHER'S NAME FIRST MIDDLE LAST Ofbin Robinson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clementine Ryan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT ADDRESS Claude Robinson Mardela, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward Peyton Richings, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Peyton Richings, M.D.				22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-21-1980		23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Mardela Wicomico Md.			
24. FUNERAL DIRECTOR NAME William M. Short Marvel-Short Funeral Home Delmar, Del.				25a. DATE REC'D. BY REGISTRAR JAN 23 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 7 3 7 REG. NO.			
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Elton RUARK										January 26, 1980 2:45a _M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 24, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 10 2		8. IF UNDER 24 HRS. HOURS MIN. 10 2			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Carpenter		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury	
14. FATHER'S NAME FIRST MIDDLE LAST John Lemuel Ruark										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia E. LeCates		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no										16b. SOCIAL SECURITY NO. 220-09-1842		17. INFORMANT ADDRESS Evelyn Dickerson Snowhill Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of lung with brain + liver metastases</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Nancy W. Tustin, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D.					22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-29-1980		23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Del.							
24. FUNERAL DIRECTOR NAME William M. Short					ADDRESS Delmar, Del.		25a. DATE REQUIRED BY REGISTRAR JAN 31 1980		25b. REGISTRAR'S SIGNATURE [Signature]				

BP

John

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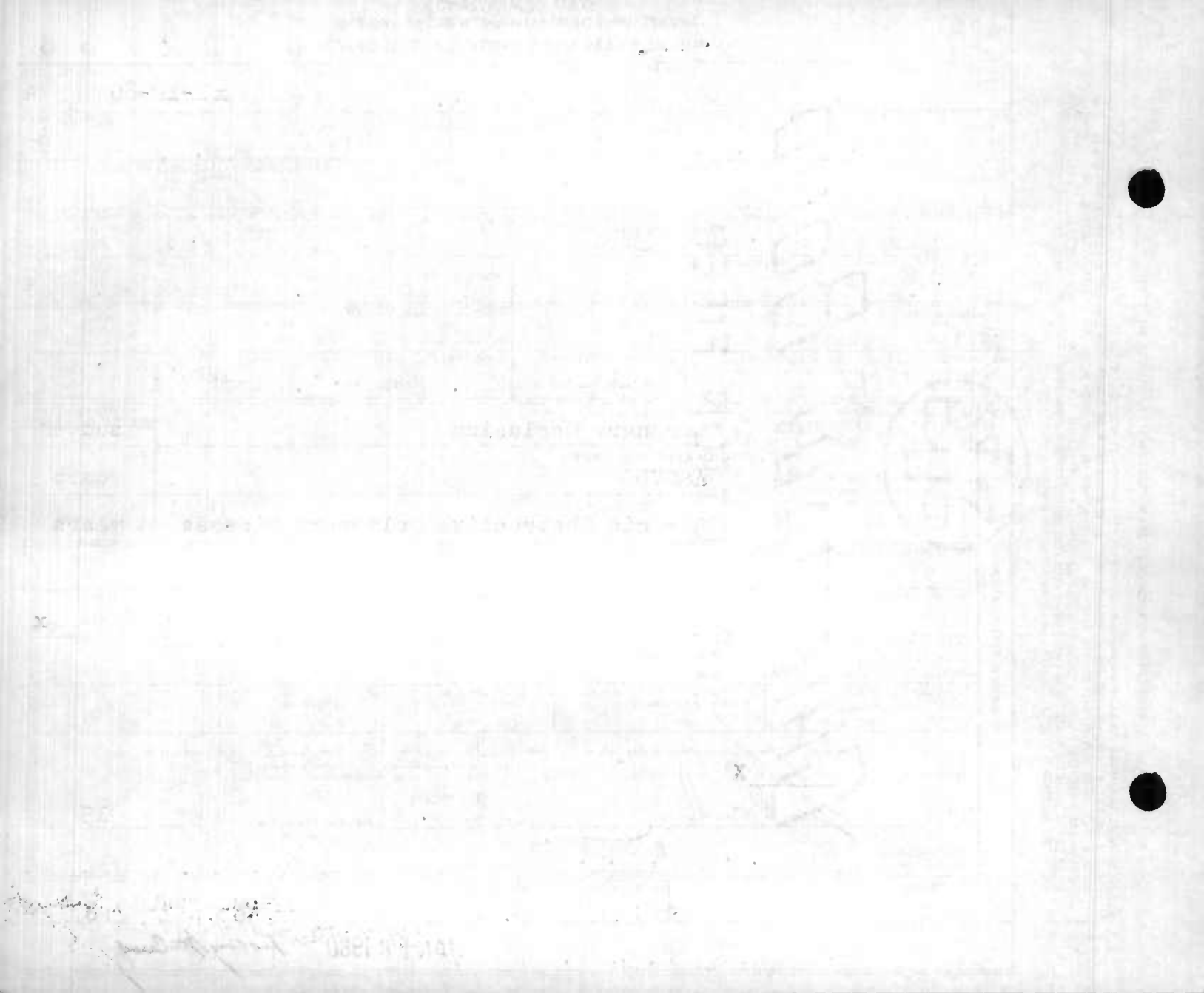
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02738			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL FLOYD RUARK, SR.										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-12-80		2b. HOUR A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1913		6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Jan. 12 1980		2d. HOUR 8 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fruitland, Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.			
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Windham Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter				12b. KIND OF BUSINESS OR INDUSTRY House Construc	
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Fruitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 309 S. Division St.			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Lawrence Ruark						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Jane Simms							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 222-01-8441		17. INFORMANT ADDRESS same as 13 Mrs. Frances M. Ruark (wife)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>496-</u> Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF ASCVD (b) Chronic Obstructive Pulmonary Disease (c) Chronic Obstructive Pulmonary Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1) OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 1/15 /80					
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/16/80		23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland					
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR JAN 16 1980				25b. REGISTRAR'S SIGNATURE <i>Harry Helling</i>					

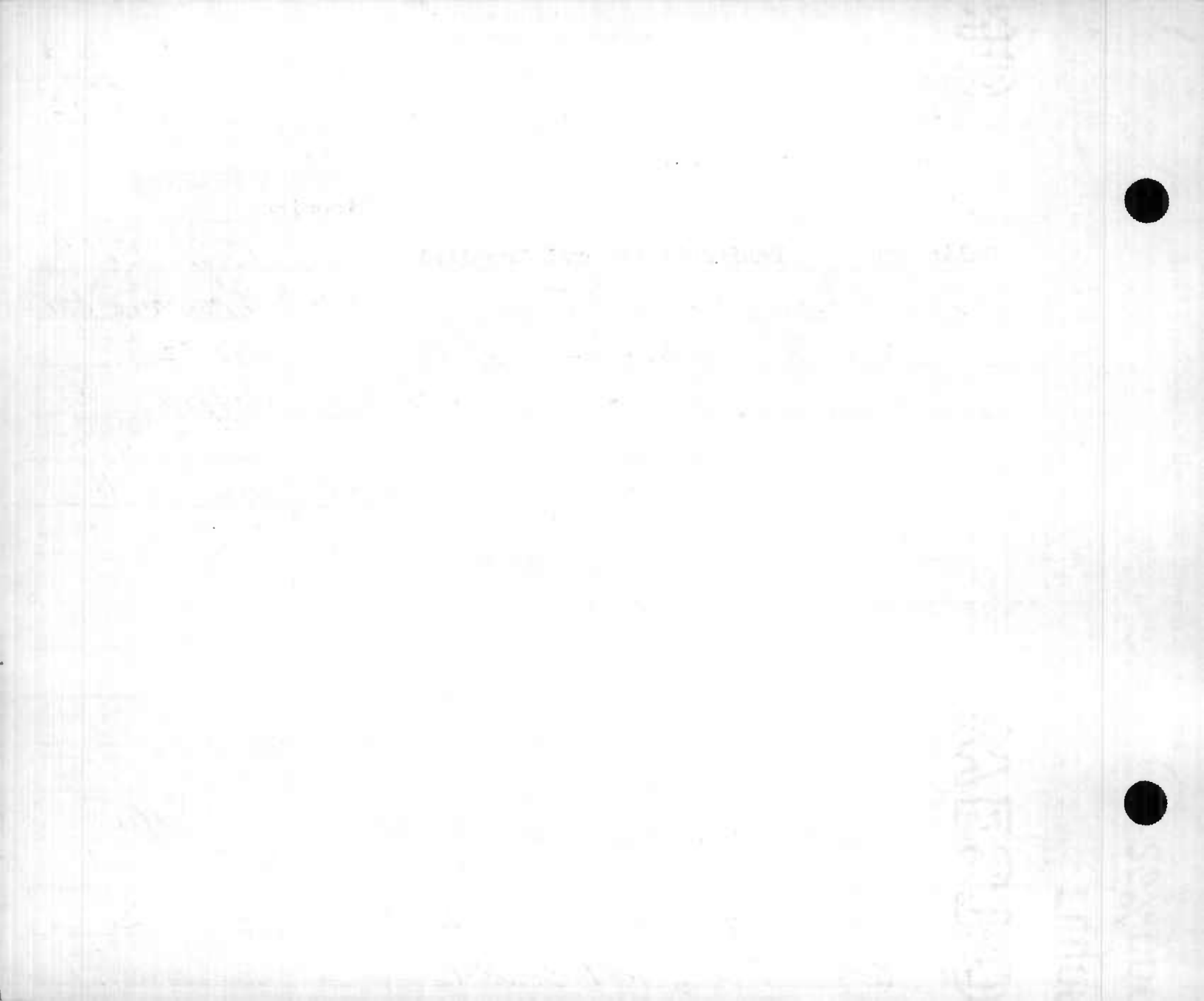


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 0 2 7 3 9 REG. NO.							
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE BURTON Schappell Jr										January 26 1980				7A M			
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		8. UNDER 74 HRS				
Male			WHITE		JAN. 8, 1910			70			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
PENN.			U.S.A.						Wicomico MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital							TERMINAL SUPP.			OIL CO.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland										Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13347 PEACHTREE Rd	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
George B. Schappell Sr										VIOLET METZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
No										194-074755		Viola Yeaker Schappell Spouse					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary failure										4/8/80							
1629																	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure, radiation pneumonia										4/8/80							
DUE TO, OR AS A CONSEQUENCE OF (c) Status post-op. Rt. pneumonectomy for CA lung										10/79							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
Old myocardial infarction; Diabetes mellitus																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 4/8 1980, to 1/26 1980, that (I) (we) lost saw the deceased alive on 1/25 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE DEGREE										22c. DATE SIGNED							
William P. Soder, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										1/26/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
										1300 S Division St., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL			1/29/1980		DORMARVA CEMETERY			Salisbury, Md.									
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hill-Baker-Bounds, Salisbury, Md.										JAN 30 1980		[Signature]					



TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8002740

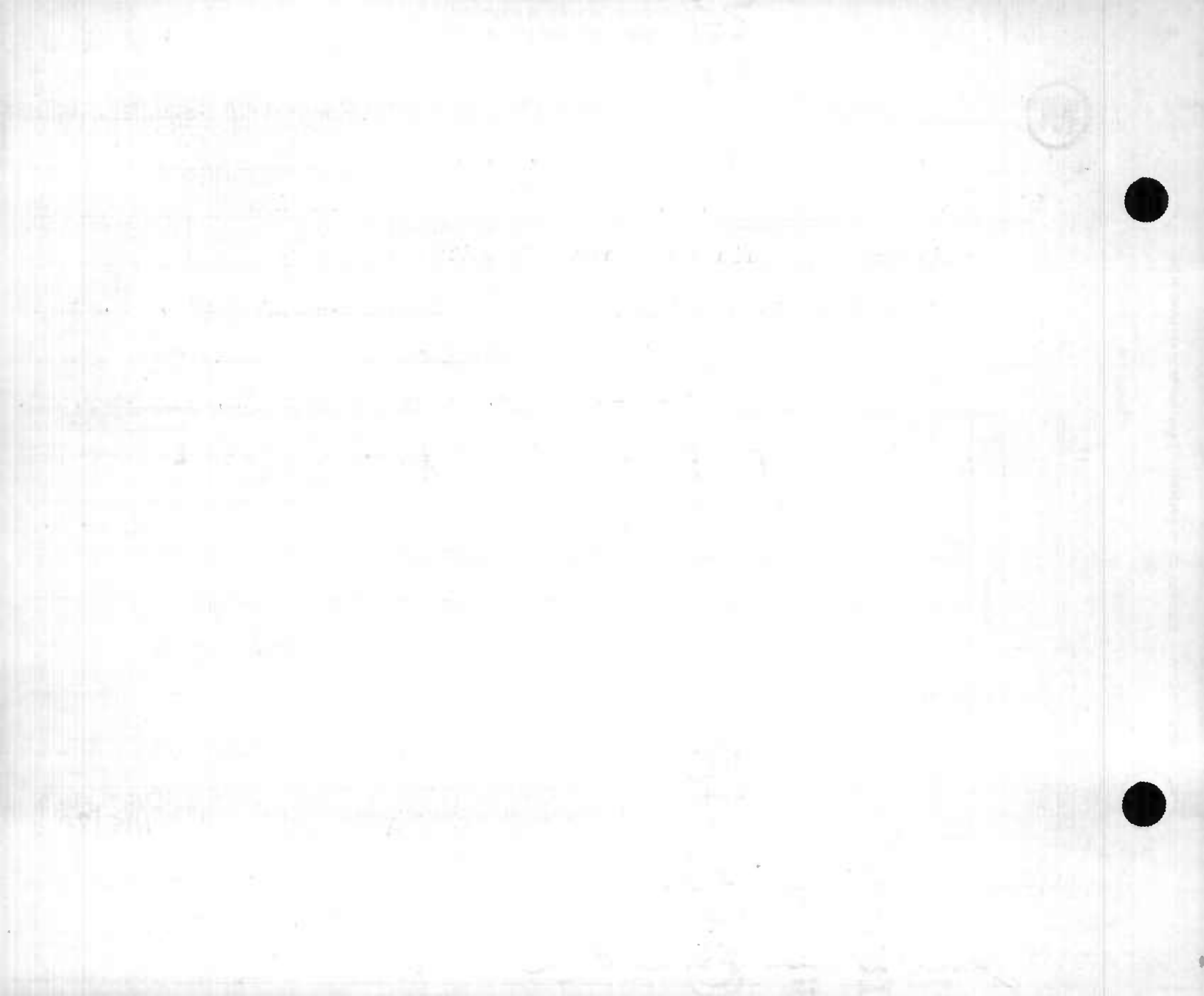
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		
Male			white			Sept. 4, 1896			83 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Germany			U. S.						Wicomico MD.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Farming					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD. #1 Westover, Md.		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Gustav Senkbeil						Pauline Betcher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
no						210-07-0795			Mrs. Margaret Senkbeil, Westover, Md.		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction & sudden death			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO, OR AS A CONSEQUENCE OF (b) advanced atherosclerotic heart disease			
DUE TO, OR AS A CONSEQUENCE OF (c) with second degree atrioventricular block.			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 12/11/79 to 1/12/80, that (I) (we) last saw the deceased alive on 1/12/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	
Joseph Z. Badros, M.D.		M.D.	
22c. DATE SIGNED		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
1/15/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Joseph Z. Badros, M.D.		P.O. Box 162, Salisbury, Md. 21801	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1/15/80	Beechwood Cemetery	Princess Anne, Somerset, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James L. L. L. L. L.	Princess Anne	JAN 22 1980	

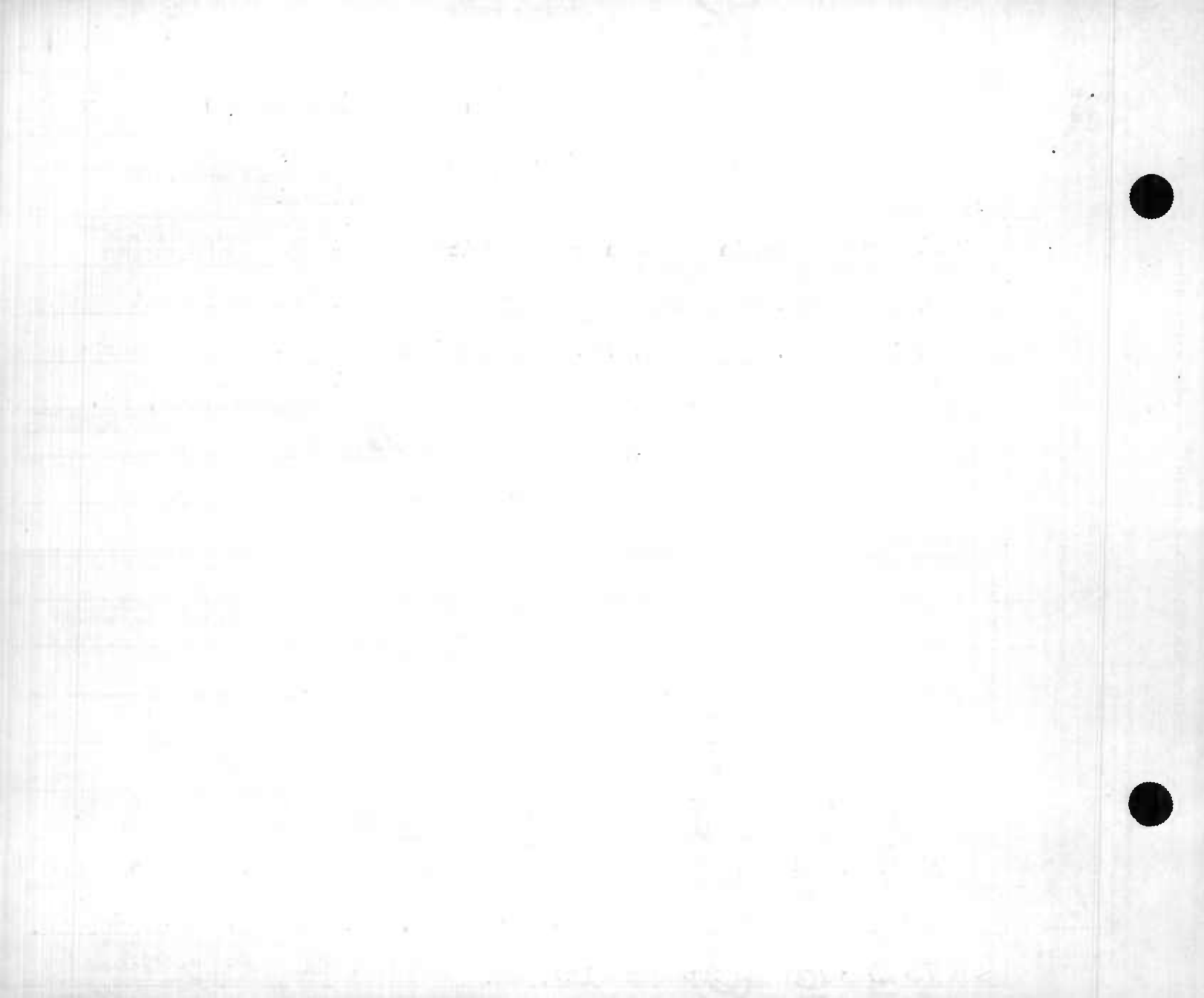


TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8002741			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK MASDEN Shaw				2b. HOUR 4:05 P.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired Businessman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Worcester Pocomoke		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 801 Walnut Street	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel W. Shaw, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise A. Hearne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-05-70691		17. INFORMANT ADDRESS 15 Clarke Avenue Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock secondary to</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>1/16</u> 19 <u>80</u> to <u>1/16</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mr. Ben Horner MD				DEGREE		22c. DATE SIGNED 1/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Ben Horner				22e. ADDRESS Kay Ave. Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/80		23c. NAME OF CEMETERY OR CREMATORY Pitts Creek Pres. Cem. Pocomoke		23d. LOCATION CITY OR TOWN COUNTY STATE Worcester Md.	
24. FUNERAL DIRECTOR NAME Swetts Melson ADDRESS Pocomoke City, Md.				25a. DATE REC'D. BY REGISTRAR JAN 24 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

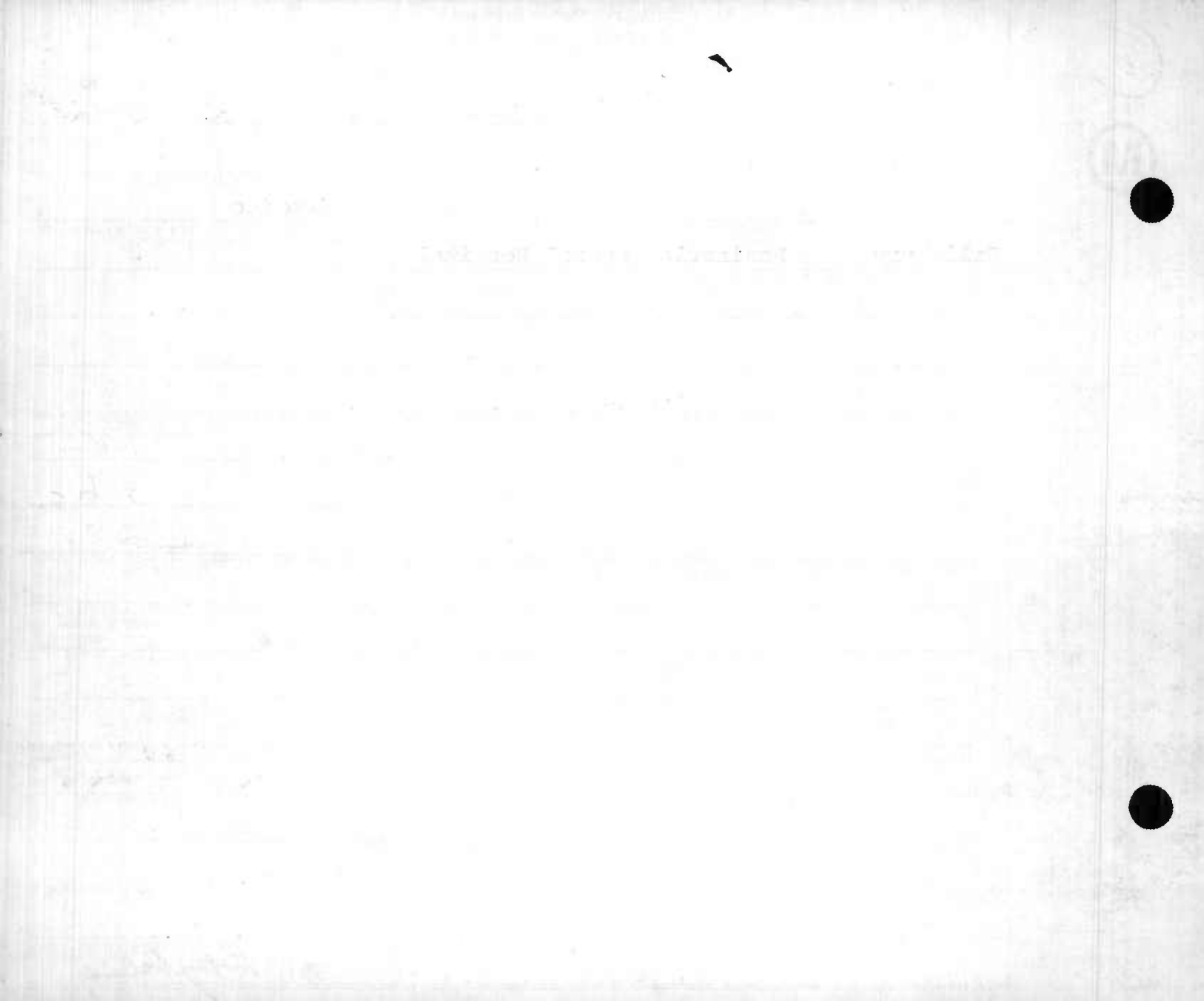


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8002742			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST (MIDDLE) LAST GERTRUDE GAY (Isakson) SNYDER				2b. HOUR 4:28 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST John Chapman Wirt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Esther Smith			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-44-6880		17 INFORMANT ADDRESS Mr. Harvey G. Snyder (husband) same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Shock</u> 4-10- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CAD</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 hr 23 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 6/1/80 to 1/30/80, that (I) (we) last saw the deceased alive on 1/30/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.							
22b. SIGNATURE J. W. Raffetto				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. W. Raffetto				22e. ADDRESS P.O. H.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/80		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic. Maryland	
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR FEB 1 1980		25b. REGISTRAR'S SIGNATURE R. H. H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002743			
1- FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) George Homer STUFFT					2a. DATE OF DEATH MONTH DAY YEAR January 12, 1980					2b. HOUR 1.00 ^M			
3 SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 28 1889		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.							
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Main St.					
14. FATHER'S NAME FIRST MIDDLE LAST Abraham G. Stufft					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Kaufman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-4409		17. INFORMANT ADDRESS Lucy J. Downey Circleville, Ohio									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cc of prostate gland & metastasis</i> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Anemia Cachexia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated otherwise (I) (we) did not view the body after death.													
22b. SIGNATURE <i>L. V. Maldve</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-12-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. V. Maldve, M.D.						22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-15-80		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Caroline Md.		25a. DATE REC'D. BY REGISTRAR JAN 16 1980					
24. FUNERAL DIRECTOR NAME <i>John E. Boulais</i> ADDRESS <i>Greensboro</i>						25b. REGISTRAR'S SIGNATURE <i>Robert H. Boulais</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) First: OTHO Middle: P. Last: TAYLOR			2a. DATE OF DEATH Month: JANUARY Day: 9 Year: 1980		2b. HOUR 8 A.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH Oct. 19, 1903		6. AGE (in years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hsp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired town employee		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 503 Walnut Street	
14. FATHER'S NAME First: Matthew Middle: L. Last: Taylor	15. MOTHER'S MAIDEN NAME First: Maggie Middle: V Last: (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. 218-05-8498	17. INFORMANT 503 Walnut Street Eva F. Taylor Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 431- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>80</u> , to <u>1/9</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph A. Grasso MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1/9/80	
22d. PHYSICIAN NAME (Type) Joseph A. Grasso MD		22e. ADDRESS SOUTH DIVISION STREET SALISBURY MD 21801			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/12/80	23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem.		23d. LOCATION (City or Town) (County) (State) Pocomoke Worcester Md.	
24. FUNERAL DIRECTOR Scott S. Melson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR JAN 14 1980	25b. REGISTRAR'S SIGNATURE [Signature]

10/10/68



10/10/68

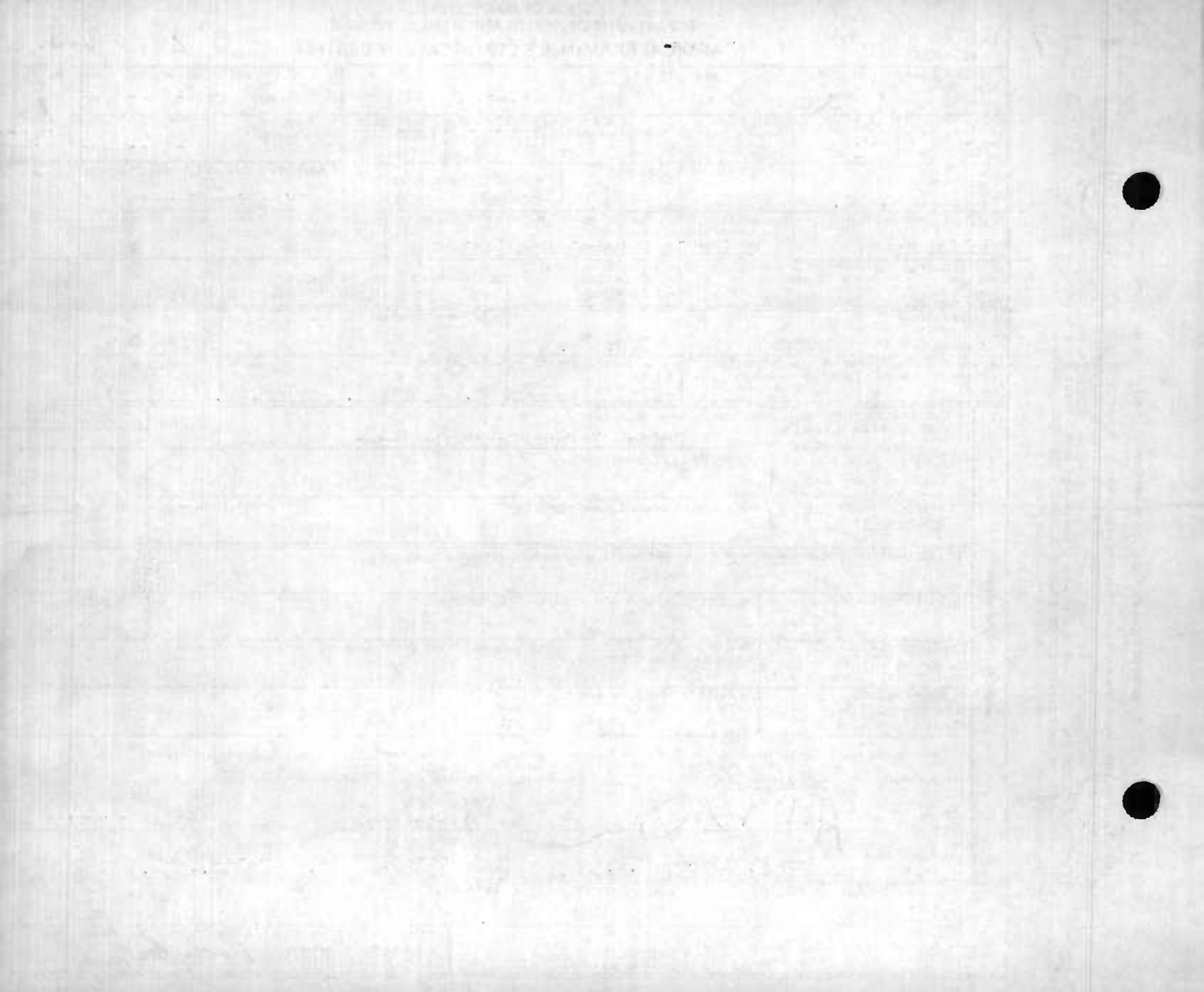
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02745

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
Sean Michael Taylor								<input type="checkbox"/> MONTH <input checked="" type="checkbox"/> 1 21 19 80				M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Male	White	9/9/1979		0 YRS.		4 12				1 21 1980				7:33A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		X		9. BALTIMORE CITY OR COUNTY OF DEATH					
Salisbury, Md.		USA				WIDOWED		DIVORCED		Wicomico County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury		Peninsula General Hospital		none		none									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		618 Priscilla Street							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Joseph Sherwood Taylor, Sr.		Deborah Ann Peacock													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No				Mr. Joseph S. Taylor, Sr. (father)		same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome															
7980 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Ann M. Dixon, M.D.				Assistant				1/22/80							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Ann M. Dixon, M.D.				111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				1/24/80				Springhill Mem. Gardens				Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
HOLLOWAY FUNERAL HOME, Salisbury, Maryland				JAN 23 1980				Anthony McCreedy							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



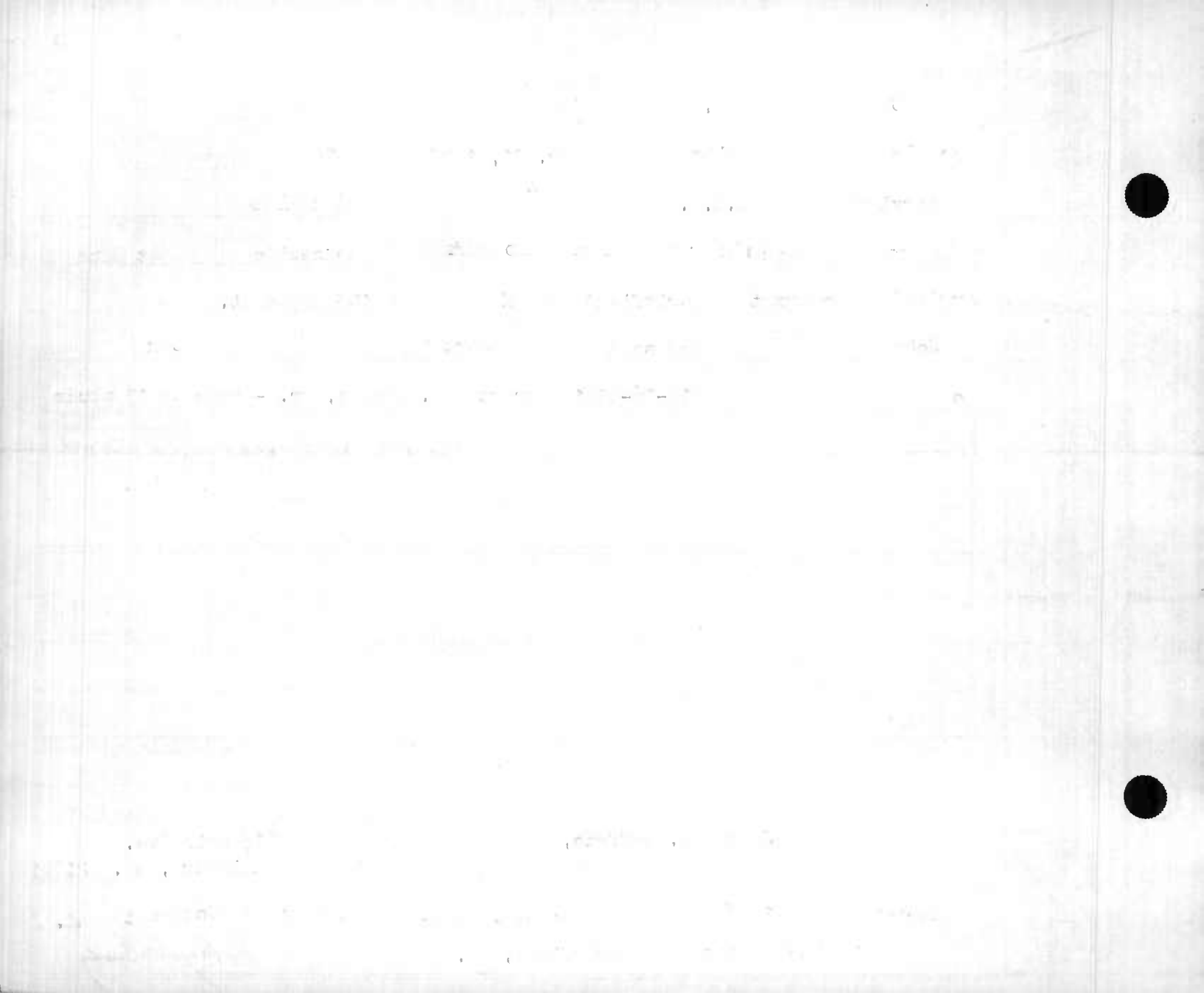
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		THOMAS		JANUARY 2 1980		8 ³² P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Female		White		Mar. 31, 1905		74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						Housewife		At Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Somerset		Grisfield				135 Maple St.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Townsend				Martha Cox							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				218-16-8581		Preston E. Thomas, Sr. - same as 13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>car accident by Thomas</u>										5 min	
4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Disease</u>										53 r	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>										103 r	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/10/79</u> to <u>1/2/80</u> , that (I) (we) last saw the deceased alive on <u>1/2/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
<u>Joseph L. Raffeto, MD</u>		MD				1/10/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Joseph L. Raffeto, MD		215 Ohio Ave. Salisbury, Md. 21801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/6/80		Sunnyridge Cemetery		Grisfield Somerset Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Bradshaw & Sons		Grisfield, Md.		JAN 1 6 1980		<u>Kathy McCreedy</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002747			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER COLEMAN THURSTON						January 4, 1980						M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1907			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 72 YRS.			IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Portsmouth, Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			MD.	
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photographer			12b. KIND OF BUSINESS OR INDUSTRY Photography	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland						13c. COUNTY Wicomico		13d. CITY OR TOWN Salisbury		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS Glen Ave. Ext.	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Cundiff Thurston						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Burke Coleman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs. Irma D. Thurston (wife) same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yrs</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1977</u> to <u>Jan 1980</u> , that (I) (we) lost <u>Jan 4</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>John T. Bulkeley M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <u>1-8-80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.						22e. ADDRESS Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/8/80		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland										25a. DATE REC'D. BY REGISTRAR JAN 11 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McLeod</u>	

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										0 REG. NO. 0 2 7 4 8	
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE KNOWN OF DEATH			ESTIMATED MONTH DAY YEAR			2b. HOUR					
LUTHER			Orville		TIMMONS						1-3-80			10:20P							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR						
Male		White		4-20-21		58 YRS.						1-3-80			"						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland				USA								Wicomico									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury				DOA Peninsula General Hospital								Trucker				Trucking					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.				Wicomico		Fruitland		YES <input type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 322, St. Lukes Road											
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
Luther				Clara																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS													
No				219-14-3927				same as 13 Mrs. Elva M. Timmons (wife)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>														sudden							
DUE TO, OR AS A CONSEQUENCE OF																					
(b) _____																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																	
20. AUTOPSY?																					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																					
TITLE (SPECIFY) Deputy MEDICAL EXAMINER																					
DATE SIGNED 1-4-80																					
ACTUAL SIGNATURE <i>Earl L. Royer</i> M.D.																					
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				1/7/80		Wicomico Memorial Park				Salisbury, Wicomico, Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.																					
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 8 1980 <i>John A. Royer</i>																					

X

10-10-10

10-10-10

X

10-10-10

10-10-10

X

X X

X

10-10-10

10-10-10

10-10-10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VRA15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 02749									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
CHERYL ANN TINDALL								1-9-80		9 P M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female	White	7-30-1959		20						1-10-80	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR	
Maryland		USA		WIDOWED		DIVORCED		Wicomico		4 A M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Eden (near)		Oak Ridge Trailer Park		Nurses Aide		Nursing Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS (mailing address)			
Md.		Somerset		Eden		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1, Box 461			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Donald Ernest Bailey		Mildred Rayne Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		same as 13			
No		216-48-7373		Mr. Jimmy D. Tindall (husband)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Bullet Wound of Brain											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		9 1-9-80 P.M.		Self-inflicted gun wound.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		own home, Oak		Ridge Trailer Park, Eden, Wic., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)								DATE SIGNED	
Earl L. Royer, M.D.		Deputy								1-11-80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		1/13/80		St. Stephens Cemetery		Delmar		Sussex		De.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HOLLOWAY FUNERAL HOME, Salisbury, Md.		JAN 14 1980		[Signature]							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 2 7 5 0			
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH		2b. HOUR	
WESLEY WADE TOWNSEND																				1-2-80		4:40 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR							
Male		White		11 30 63		16 YRS.		1 2				1-2-80		19		"							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.							
Maryland				U. S. A.								Wicomico											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury				DOA Peninsula General Hospital								student											
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
De.										Sussex		Delmar		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 90 AA							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST										FIRST MIDDLE LAST													
Wesley Everett Townsend										Brenda Sue Collins													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
no										221-56-2180		Wesley E. Townsend Delmar, Del.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Fracture of Skull</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(b) <u>8191</u>																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
										4:05 P. M.		1-2-80 Passenger in auto involved in crash.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION											
										road		Waller Road, west of Delmar, Wic., Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE										TITLE (SPECIFY)				DATE SIGNED									
<i>Earl L. Royer</i>										M.D. Deputy				1-3-80									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS													
Earl L. Royer, M.D.										409 Camden Ave., Salisbury, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial										1-5-1980		St. Stephens				Delmar Sussex Del.							
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Marvel-Short William M. Short Jr.										JAN 9 1980				<i>Jeffrey McBrady</i>									
26. FUNERAL HOME										27. REGISTRAR'S SIGNATURE													
Marvel-Short Funeral Home, Delmar, De.																							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) REBA REBECCA VINCENT					2a. DATE OF DEATH MONTH DAY YEAR 1-27-80					2b. HOUR 8:35P ^M
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 11 96		6 AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) River Walk Manor				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Floorlady		12b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg. Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Oliver C. Tice					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Shaw					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214-10-9574		17. INFORMANT ADDRESS Lemon Hill, Salisbury, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 4 yrs 4 wks										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u> , 19 <u>79</u> , to <u>Jan 27</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John T. Bulkeley					DEGREE M.D.			22c. DATE SIGNED 1-28-80		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D.					22c. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/30/80		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR JAN 29 1980					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8002752	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <u>James</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>JANUARY 23 1980</u>		2b. HOUR <u>2:30</u> M			
3. SEX <u>male</u>		4. RACE <u>black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Dec. 24, 1942</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>37</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.					
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>ret. laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Md.</u> 13c. COUNTY <u>Worcester</u>		13d. CITY OR TOWN <u>Bishopville</u>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS <u>R.D. 1 Box 188</u>					
14. FATHER'S NAME FIRST MIDDLE LAST <u>William Walters</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Rose Handy</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO <u>214-18-4448</u>		17. INFORMANT ADDRESS <u>Gertrude Walters - Bishopville, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>congestive heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (the hospital) attended the deceased from <u>1/22</u> , 19 <u>80</u> , to <u>1/23</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <u>Rodney A. Wernich</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>1/23/80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RODNEY A. WENRICH</u>		22e. ADDRESS <u>KAY AVE. SALISBURY Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/26/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tyree Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Berlin, Wor. Co., Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Richard T. Watson</u>		ADDRESS <u>Middlebrook Rd.</u>		25a. DATE REC'D BY REGISTRAR <u>FEB 1 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8002753

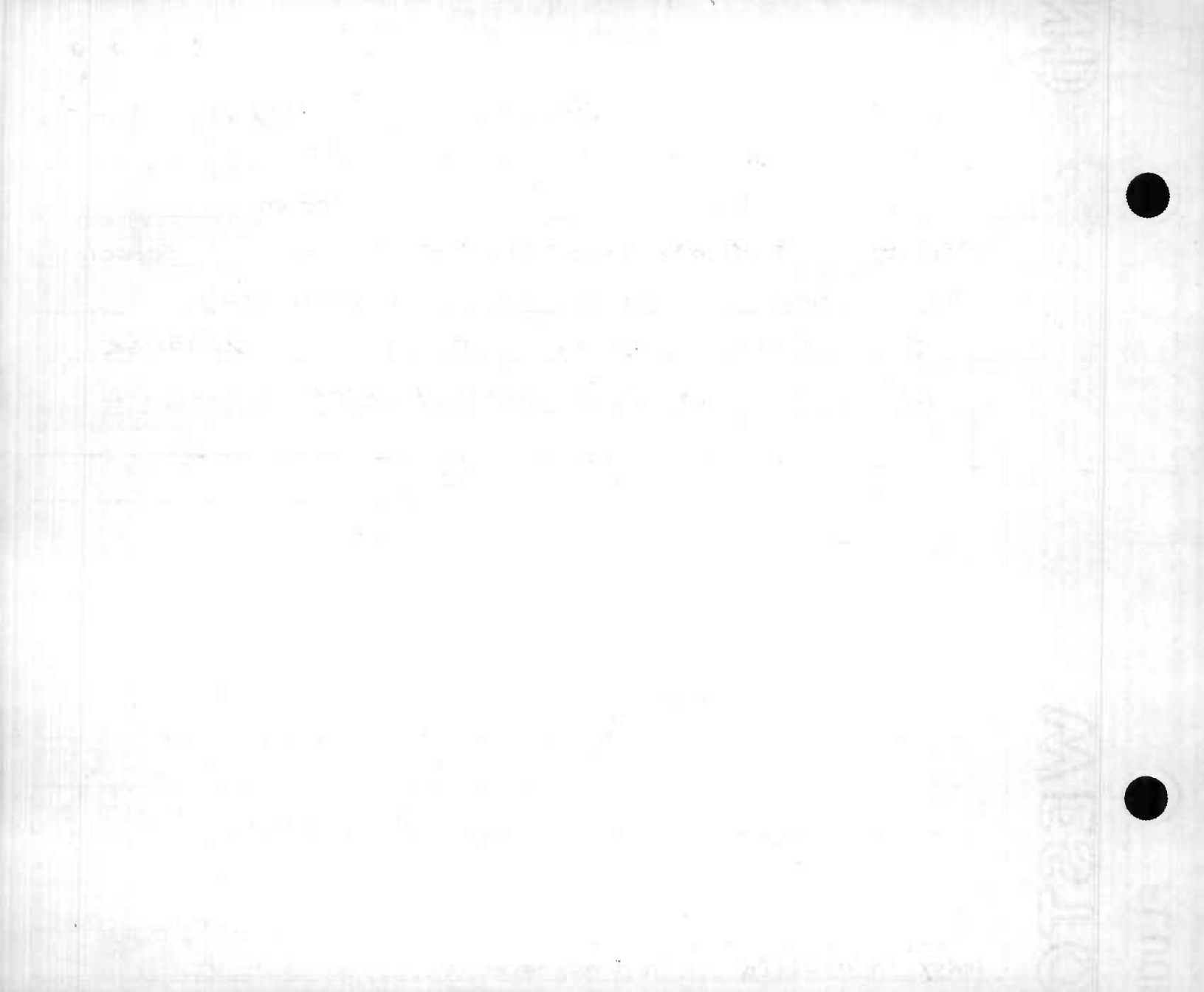
1. DECEASED NAME (TYPE OR PRINT) ADDIE H. Webster			2a. DATE OF DEATH MONTH DAY YEAR January 18 1980			2b. HOUR 2A M				
3 SEX Female		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 6 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY Som.		13c. CITY OR TOWN WENONA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS MAIN ROAD	
14 FATHER'S NAME FIRST MIDDLE LAST J. ELMER WEBSTER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE WEBSTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-34-3980		17 INFORMANT ADDRESS ANNABELLE DARBY PR. ANNE, MD.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock 5698 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aorta abdomen (c) perforated Bowel		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Gut - stage 1 renal failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 1/17/80 to 1/18/80, that (I) (we) last saw the deceased alive on 1/17/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Constant J Tan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Constant J Tan				22e. ADDRESS 547-D Riverside Dr., Salisbury MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 20, 1980		23c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CHURCH CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WENONA Som. MD.	
24 FUNERAL DIRECTOR NAME LEROY G. WEBSTER				ADDRESS RT. 3 Box 354 PR. ANNE, MD, 21853		25a. DATE REC'D. BY REGISTRAR JAN 22 1980	
				25b. REGISTRAR'S SIGNATURE Ruthy McLeod			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8002754		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
MAX EDWIN Wells				January 6 1980				932 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		Aug. 7, 1916		63 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Salisbury, Md.		USA				Wicomico			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Truck Driver		Creosote Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Wicomico		Quantico		YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT (sister) ADDRESS	
Edwin Howard Wells		Dollie Colburn Brittingham		Yes		WW II 214-10-6606		Mrs. Ruth G. Townsend, Salisbury, Md. 502 Winder St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4374		Ventricular fibrillation		Rapid Pulmonary disease & acidosis		Advanced Pulmonary obstructive disease with clots			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				116		116		1980	
22a. I certify that (I) (this hospital) attended the deceased from		1980		to		116		1980	
saw the deceased alive on		116		1980		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Joseph Z Badros		M.D.				116/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Joseph Z Badros		229 Florida Ave Salisbury Md.		Burial		1/10/80		Parsons Cemetery	
24 FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY FUNERAL HOME, Salisbury, Maryland				JAN 8 1980					



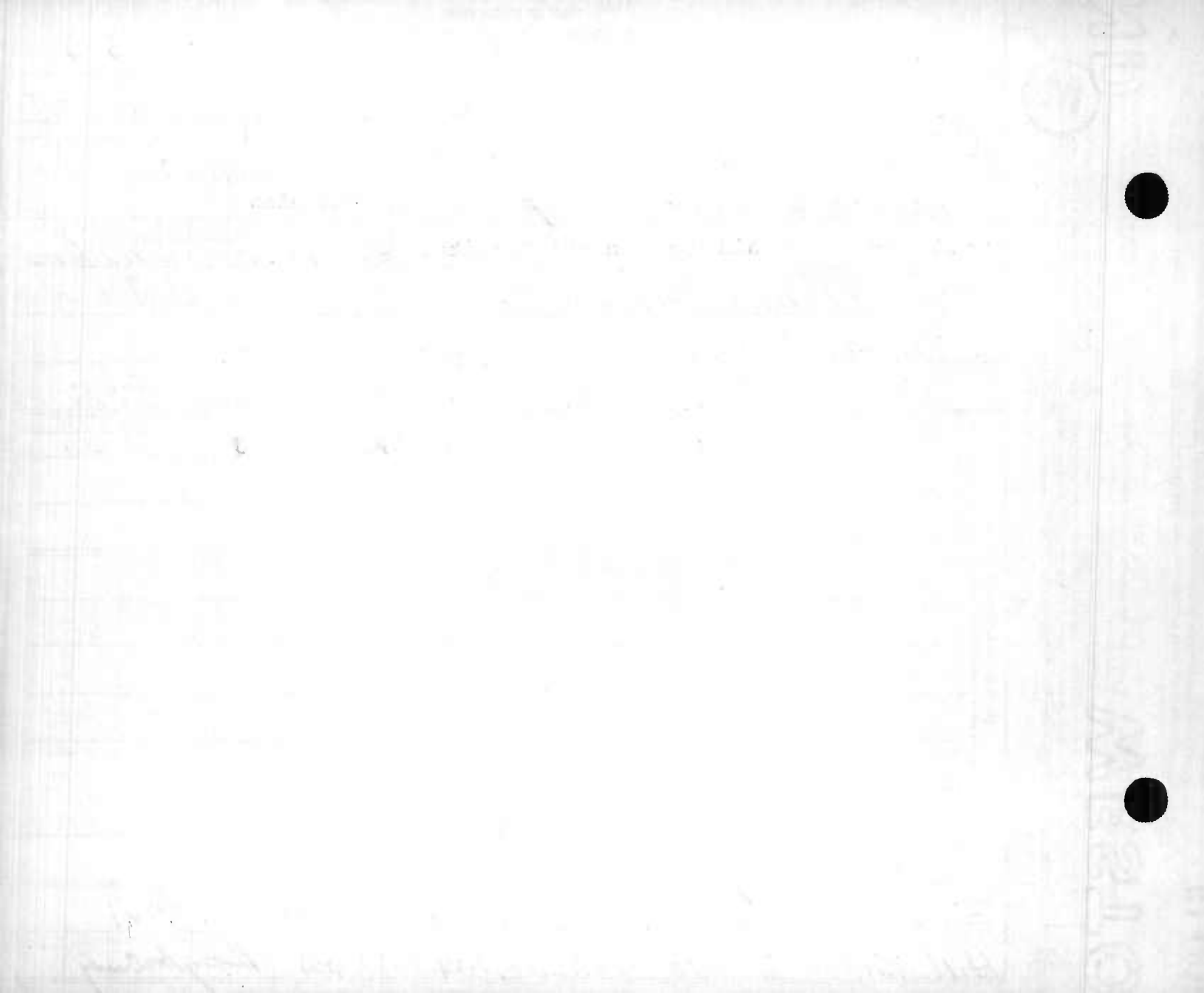
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8002755									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MYRA		Baker		WHITE				January 12, 1980		3:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		11-6-1888		91 YRS					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Wicomico MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital						HOUSEWIFE		Crew Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Wicomico		Salisbury		YES		Lemon Hill			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
SANFORD		DENNIS		ANNIE		POWELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		214-10-6417		LORRA B. PARSONS		Home - Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) 4140										Interval	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Secondarily aneurysm											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-2, 1980, to 1-12, 1980, that (I) (we) last saw the deceased alive on 1-12, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
WILLIAM R. ELLIS, MD.		MD						1-12-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
WILLIAM R. ELLIS, MD.											
23a. BURIAL, CREMATION, REMOVAL (FOR BURIAL)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		1/15/80		Wicomico Mem. PK.		Salisbury		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hill-Baker-Bounds		Salisbury, Md.		JAN 16 1980		Ruthy H. Bandy					

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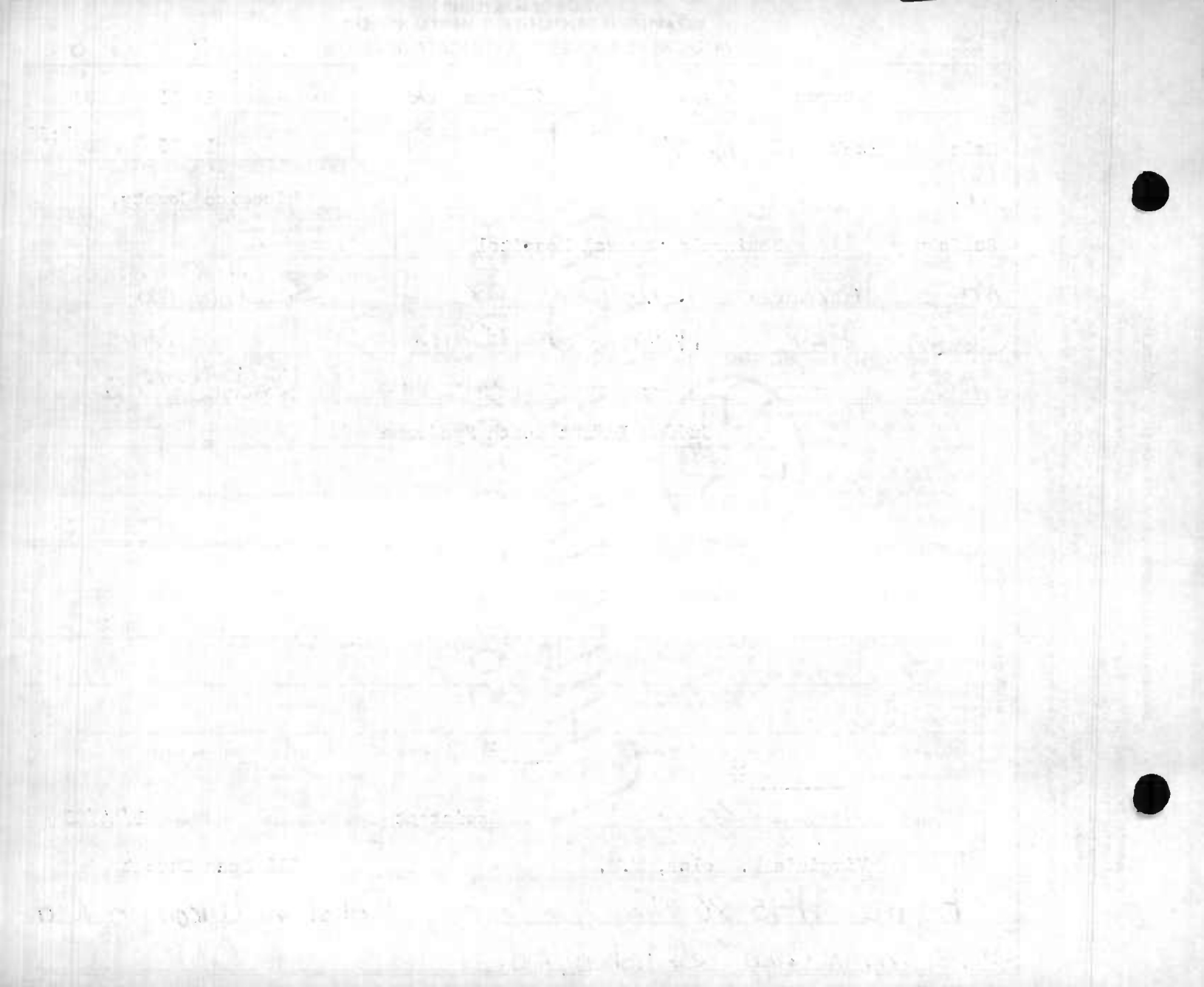


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 02756	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Steven RAY Williams JR.						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1 13 19 80				2b. HOUR M 13			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 16 79		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS 28		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 13 19 80		2d. HOUR A M 7:55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD	
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 112 Catherine St. Salisbury, Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Steven RAY Williams Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Onita Mills							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Onita Mills				ADDRESS 112 Catherine St. Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Sudden Infant Death Syndrome IMMEDIATE CAUSE (a) 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 1/14/80	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-15-80		23c. NAME OF CEMETERY OR CREMATORY Green Acres Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md			
24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel				ADDRESS Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR JAN 22 1980				25b. REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

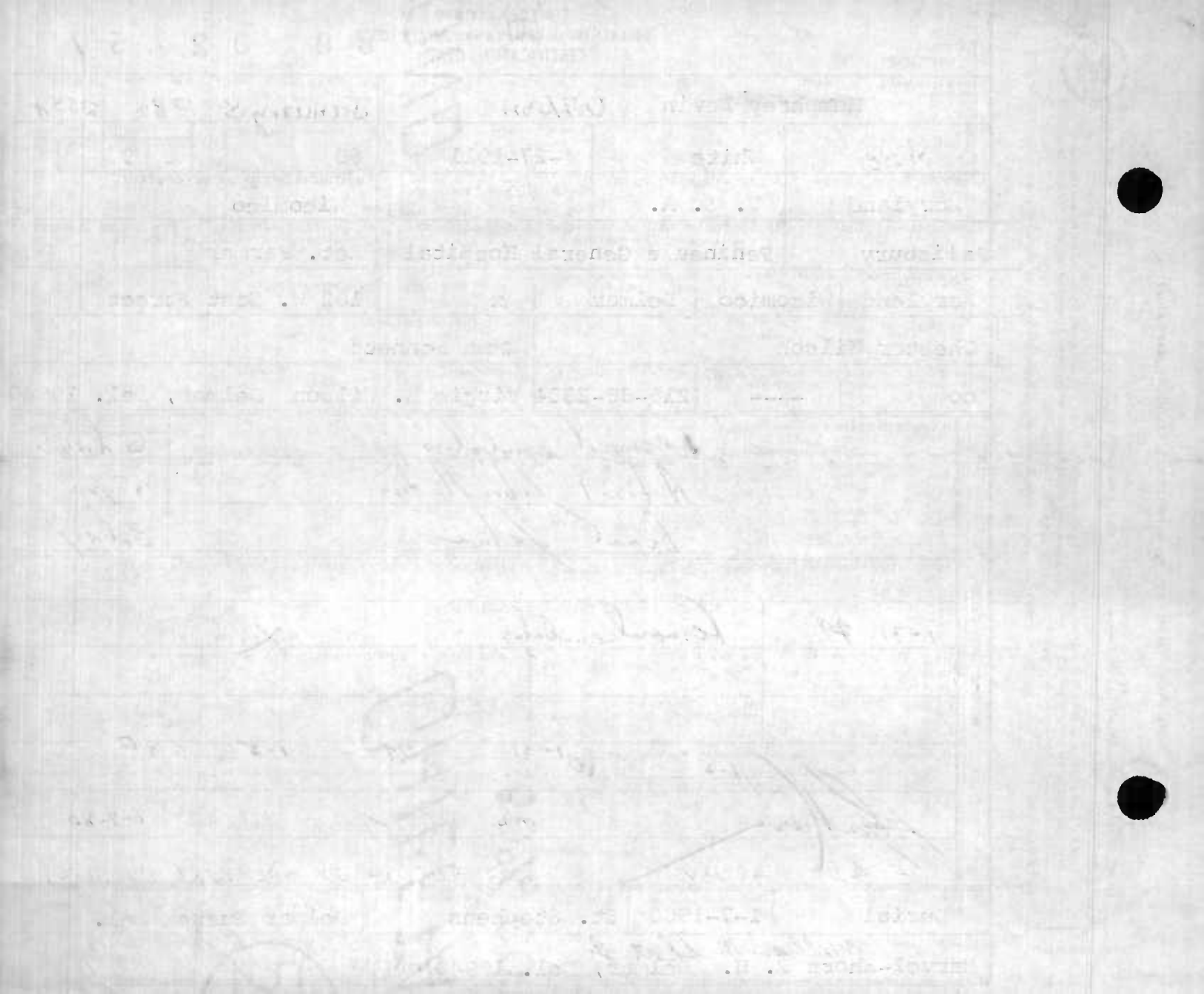
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DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 60 02757

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Humphrey Levin Wilson		January 5 1980		2054 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
male	White	4-27-1911	68	MONTHS 8 DAYS 9	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U. S. A.		Wicomico MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital		Ret. Farmer		
13a. STATE			13b. COUNTY		
Maryland			Wicomico		
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Delmar			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Chester Wilson			Emma Bennett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-36-2334		Virgie E. Wilson Delmar, Del. 19940	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Removal embolus</u> 4273 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>A frontal lobe, No tion</u> (c) <u>Renal failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 15 yrs 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
1-31-89		Removal embolus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-31, 19 79, to 1-5, 19 80, that (I) (we) last saw the deceased on 1-5, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.		22b. SIGNATURE E. Kent Carney		22c. DATE SIGNED 1-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
E. KENT CARNEY		233 FLORIDA AVE SALISBURY MD 21801		JAN 11 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1-7-1980		St. Stephens	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
William M. Short Jr.		Marvel-Short F. H. Delmar, Del. 19940		JAN 11 1980	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 2 7 5 8

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Clyde Albin WINDSOR		2a. DATE OF DEATH MONTH DAY YEAR 1-14-80		2b. HOUR 9:50 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8-30-92		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD.		10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER & Box Builder Ret		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Windsor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith MARINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-03-5869		17. INFORMANT ADDRESS FRANCES HARVEY WINDSOR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) leiomyosarcoma of lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) leiomyosarcoma of lung					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/14 19 77		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/14 19 77 to 1/14 19 80 , that (I) (we) lost the deceased alive on 1/14 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If certified, do not use the body after death.)					
22b. SIGNATURE Earl M. Beardsley		DEGREE MD		22c. DATE SIGNED 1/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.		22e. ADDRESS Civic Ave, Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/17/1980		23c. NAME OF CEMETERY OR CREMATORY PARSONS Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Md		24. FUNERAL DIRECTOR NAME ADDRESS Hill-Baker-Bounds, Salisbury Md		25a. DATE REC'D. BY REGISTRAR JAN 21 1980	
25b. REGISTRAR'S SIGNATURE Henry McCreedy					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO BALTIMORE CITY OR COUNTY OF DEATH: This certificate should be filed with the Baltimore City or County Health Department within 72 hours after death.

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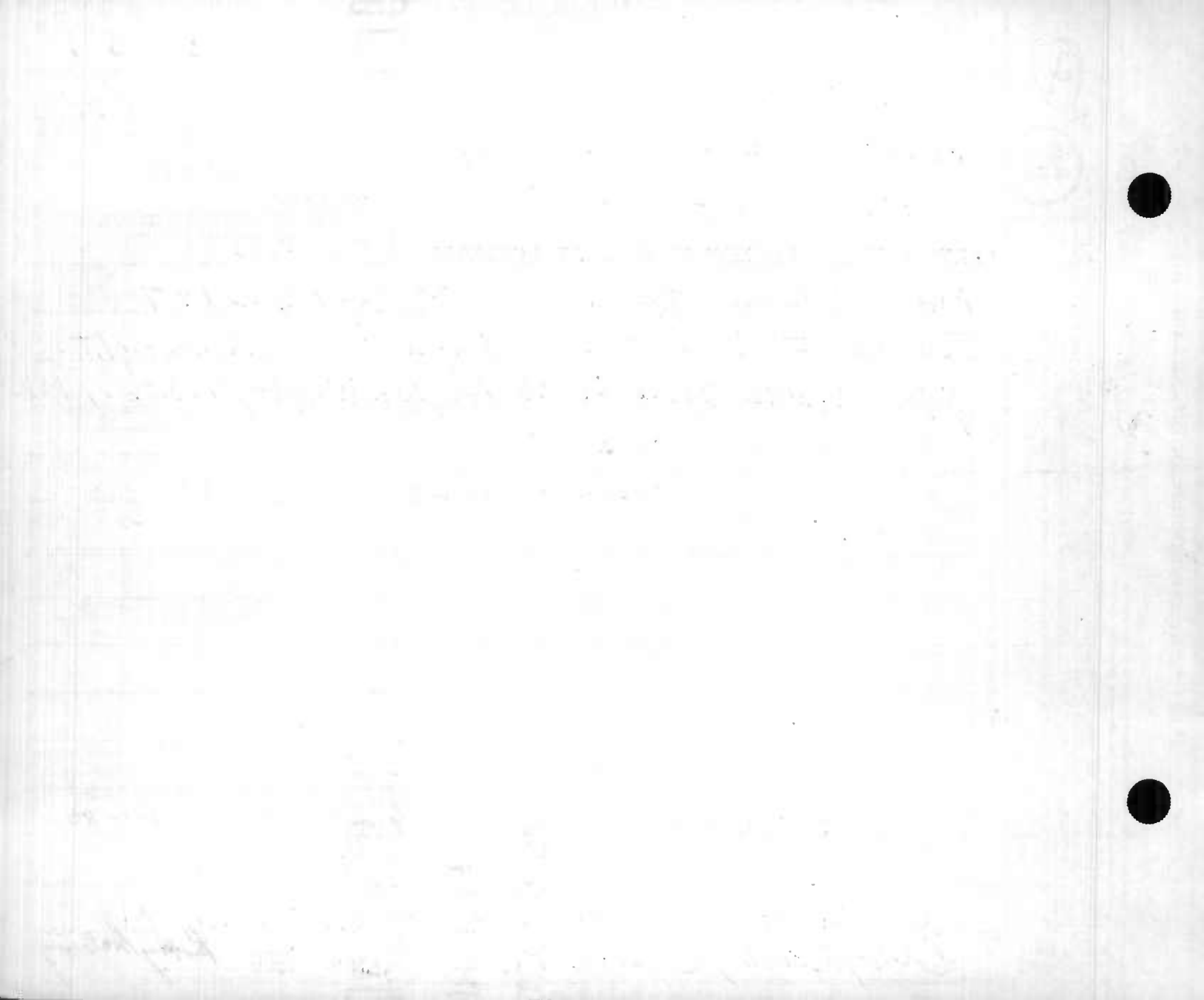


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3002759			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Wilmer		MIDDLE J.		LAST WRIGHT		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 6 1980				2b. HOUR 3P. M.	
3 SEX Male		4 RACE A A		5. DATE OF BIRTH MONTH DAY YEAR 6-20-1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.							
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sea Food		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Wicomico		13c. CITY OR TOWN Tyaskin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 197					
14. FATHER'S NAME FIRST MIDDLE LAST James F. Wright				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Wainwright									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WWII				16b. SOCIAL SECURITY NO. 217-07-6788		17. INFORMANT ADDRESS Hughes Wright, Quantico, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Repetitive stress</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>30 Dec 79</u> , 19 <u>79</u> , to <u>1-6</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>1-6</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE E T Colwell				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-6-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E T Colwell				22e. ADDRESS PGH Salisbury Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/10/80		23c. NAME OF CEMETERY OR CREMATORY Whitehaven Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Whitehaven Md			
24. FUNERAL DIRECTOR NAME C. J. Pressick				ADDRESS Bridgetown, Md.				25a. DATE REC'D. BY REGISTRAR JAN 9 1980		25b. REGISTRAR'S SIGNATURE Anthony M. Brady			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				30002760 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Lillie Mae Zimmer				2a. DATE OF DEATH MONTH DAY YEAR January 1-1980				2b. HOUR 11:18 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1900				6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Self			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia				13b. COUNTY Accomack		13c. CITY OR TOWN Chincoteague		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 205 North Main Street	
14. FATHER'S NAME FIRST MIDDLE LAST John William Birch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-56-6609		17. INFORMANT ADDRESS Thelma Jester, Chincoteague, Virginia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 410- DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction 6 days. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease 60 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (this hospital) attended the deceased from 1-27-1979, to 1-1-1980, that (he) (we) last saw the deceased alive on 1-1-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)											
22a. SIGNATURE Roger Merrill M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1.1.80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Merrill				22e. ADDRESS 307 Kay Ave, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-4-80		23c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oak Hall, Virginia			
24. FUNERAL DIRECTOR NAME Salger Funeral Home, Chincoteague, Virginia				25a. DATE REC'D. BY REGISTRAR JAN 8 1980				25b. REGISTRAR'S SIGNATURE [Signature]			

BP _____

